NORTH CENTRAL DISTRICT HEALTH DEPARTMENT

Community Health Improvement Plan

Serving the counties of Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock

2013

422 East Douglas Street O'Neill, NE 68763

TABLE OF CONTENTS

1. INTRODUCTION

The North Central District Health Department (NCDHD) is a state-approved district health department that provides a broad array of services to its service area. The NCDHD serves nine rural Nebraska counties—Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Rock and Pierce—that cover 14,455 square miles. The NCDHD has been state-approved as a multi-county public health department, a government body at the county level, since December 2001, providing education and services to the nine-county area. The NCDHD started out in 1999 as a nine-county community public health coalition, North Central Community Care Partnership (NCCCP), covering the same counties it does today as a governmental public health department. NCCCP was instrumental in aligning all nine counties, with their elected officials, to sign an inter-local agreement, joining all nine counties together as a single governmental department. NCCCP continues to be vibrant today, working as a public health coalition for the NCDHD. In 2007 the Board of Health for the NCDHD voted to recognize NCCCP as the official strategic planning partner of NCDHD and its nine counties.

NCDHD is well recognized locally and state-wide for its community health assessment, planning and implementation work. This is the third assessment and planning process completed in our nine counties since 1999; the first one completed by NCCCP and the last two directed under the guidance of NCDHD. The district has worked through many components of the Mobilizing for Action through Planning and Partnership (MAPP) process as this has been the guiding plan used by NCDHD and NCCCP. As this is the third process of assessment and planning the district has completed, it has been designed to be broader than either of the first two iterations and has been done to meet not only the Community Health Needs Assessments of the district, but also to meet the needs of the area hospitals, eight of which must comply with new Internal Revenue Service (IRS) requirements.

2. PLAN OWNERSHIP

Background Data to Support Hospital and Local Public Health Joint Ownership in the Community Health Improvement Plan

There are many reasons why, in our third process of community needs assessment and planning, it was logical for the North Central District Health Department to partner with the eleven district hospitals to complete a joint Community Health Improvement Plan (CHIP). The major reason is to improve overall community health through the assistance of multiple partners. Additional reasons for collaboration exist: eight of our eleven local hospitals are now required to complete both a Community Health Needs Assessment and Community Health Improvement Plan to meet IRS requirements to maintain their non-profit status. Those hospitals are:

Antelope Memorial Hospital, Neligh, NE (Antelope County)
Avera Creighton Hospital, Creighton, NE (Knox County)
Avera Saint Anthony's Hospital, O'Neill, NE (Holt County)

Osmond General Hospital, Osmond, NE (Pierce County)
Plainview Community Hospital, Plainview, NE (Pierce County)
Tilden Community Hospital, Tilden, NE (Antelope County)
Niobrara Valley Hospital, Lynch, NE (Boyd County)
West Holt Memorial Hospital, Atkinson, NE (Holt County)

While the other three hospitals are not required to complete a Community Health Needs Assessment or Community Health Improvement Plan, working with them to create community-specific plans will help to make NCDHD's overall Community Health Improvement Plan more meaningful. Those hospitals are:

Brown County Hospital, Ainsworth, NE (Brown County)
Cherry County Hospital, Valentine, NE (Cherry County)
Rock County Hospital, Bassett, NE (Rock County)

Some of the major drivers toward a new, higher level of collaboration between the health department and the hospital include:

1. Nebraska State Statutes

   Nebraska Statutes under 71-1628.04 provide guidance on the roles public health departments must play and provide the following four of ten required elements which fit into the public health role in the Community Health Improvement Plan.

   ...Each local public health department shall include the essential elements in carrying out the core public health functions to the extent applicable within its geographically defined community and to the extent funds are available. The essential elements include, but are not limited to, (a) monitoring health status to identify community health problems, (b) diagnosing and investigating health problems and health hazards in the community, (c) informing, educating, and empowering people about health issues, (d) mobilizing community partnerships to identify and solve health problems…

2. A History of Working Together on Previous Community Improvement Plans

   The North Central Community Care Partnership (NCCCP) set the groundwork for public health assessment in our nine counties by completing a Community Health Needs Assessment and developing a community improvement plan in 1999. In that year, NCCCP worked collaboratively with many public health partners, including our local hospitals, and contracted with Tripp Umbach & Associates, Inc. to complete a random sample community health needs assessment. Since then, North Central District Health Department (NCDHD) has been using the MAPP process, and/or components thereof, to meet the requirements of the Nebraska Statute. The NCCCP and NCDHD have worked to involve all the hospitals in its service area in this process since 1999. Thus, we have three assessment processes and have benchmarks to measure against.

3. The Patient Protection and Affordable Care Act Impact on Hospitals

   The historic passage of the Patient Protection and Affordable Care Act (PPACA) has called on non-profit hospitals to increase their accountability to the communities they serve. PPACA creates a new Internal Revenue Code Section 501(r) clarifying certain responsibilities for tax-exempt hospitals. Although tax exempt hospitals have long been required to disclose their community benefits, PPACA adds several new requirements.

   Section 501(r) requires a tax-exempt hospital to:

   - Conduct a community health needs assessment every 3 years
     - The assessment must take into account input from persons who represent the broad interests of the community served, especially those of public health
   - Develop an implementation plan and strategy that addresses how a hospital plans to meet EACH of the health care needs identified by the assessment
     - This plan must be adopted by the governing body of the organization, and must include an explanation for any assessment findings not being addressed in the plan
   - Widely publicize assessment results

   As mentioned earlier, this requirement affects eight of the eleven hospitals in the NCDHD service area.

4. Redefinition of Hospital Community Benefit

   Hospitals have been providing community benefits for many years in a variety of ways. In return, hospitals receive a variety of local, state, and federal tax exemptions. The activities listed under "community benefit" are reported on the hospital's IRS 990 report.

   Community benefit has now been defined by the Internal Revenue Service (IRS) as "the promotion of health for a class of persons sufficiently large so the community as a whole benefits." Simply put, community benefit is composed of programs and services designed to address identified needs and improve community health. To qualify as community benefit, initiatives must respond to an identified community need and meet at least one of the following criteria:

   - Improve access to healthcare services
   - Enhance health of the community
   - Advance medical or health knowledge
   - Relieve or reduce the burden of government or other community efforts

5. Public Health Accreditation Requirements

   In July of 2011, the Public Health Accreditation Board (PHAB) released the first public health standards for the launch of national public health department accreditation. All local health departments (LHDs) must have completed a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). PHAB Version 1.0 has standards that require the LHD to:

   - Participate in or conduct a collaborative process resulting in a comprehensive community health assessment
   - Collect and maintain reliable, comparable and valid data
   - Conduct a process to develop community health improvement plan
   - Produce a community health improvement plan as a result of the community health improvement process
   - Implement elements and strategies of the health improvement plan in partnership with others
   - Analyze public health data to identify health problems that affect the public's health
   - Provide and use the results of the health data analysis to develop recommendations regarding public health policy, processes, programs or interventions

3. PLANNING PROCESS

MAPP: The evidenced-based process used for the CHNA and CHIP
North Central District Health Department has been responding to the need for community assessments using the Mobilizing for Action through Planning and Partnership (MAPP) process. The MAPP process was developed by and is recommended for community assessment by the National Association of City and County Health Officials (NACCHO) and Centers for Disease Control (CDC). MAPP was also recommended by the Nebraska Rural Health Association in its *"Community Health Assessment Collaborative Preliminary recommendations for Nebraska's community, nonprofit hospitals to comply with new requirements for tax exempt status enacted by the Patient Protection and Affordable Care Act"* (September of 2011).

MAPP was chosen, in part, because the process allows for input from parties who represent broad interests in the communities. Input from diverse sectors involved in public health, including medically underserved, low-income, minority populations and individuals from diverse age groups, was obtained through surveys and targeted focus groups by way of invitations to community leaders and agencies.

Many of the 11 hospitals in this nine-county area have participated with the previous assessments. During this third iteration of the MAPP process, NCDHD served as the lead agency with support from all hospitals through both personnel and financial resources.

MAPP involves gathering together multiple community stakeholders for a shared assessment, strategic planning, and implementation process. The MAPP cycle has well defined steps and processes to capture community input and move a community or organization to make positive changes.

4. COMMUNITY HEALTH NEEDS ASSESSMENT METHODOLOGY

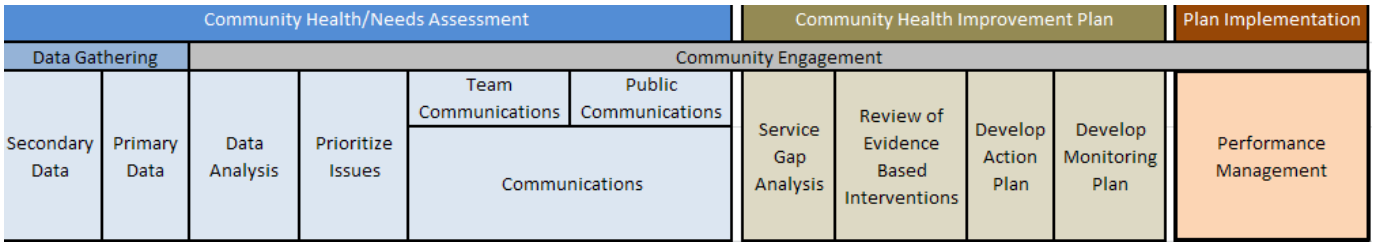
Gathering Data

In looking at the plan process template below, it can be seen that data gathering is the first step in completing the CHNA. Data gathering was accomplished using the four MAPP model assessments and included both primary and secondary data sources.

The Community Health Needs Assessment (CHNA) has been completed three times since 1999, with the most recent assessment completed by October of 2012. The most recent assessment findings are available online for public review at www.ncdhd.ne.gov.

The table below can serve as a summary of the process used in planning the joint CHNA and joint CHIP for the NCDHD, 11 area hospitals, and other district partners. As you can see, the plan involves three major themes: the Community Health Needs Assessment (CHNA), the Community Health Improvement Plan (CHIP) and the Plan Implementation. Various activities that are part of the overall process appear under each section.

It is important to note that Community Engagement is an overarching concept encompassing the majority of the CHNA and CHIP process and will be discussed under each area. Community Engagement was also a major part of the data gathering process.



The first assessment is the Community Themes and Strengths Assessment which is a subjective look at how the community views their health to capture the perceived needs of the community. This assessment ranks high for community involvement. This step was completed through focus groups in the counties, as well as telephone surveys conducted by the state of Nebraska. The data for this assessment was collected over a six-month period and included 500 written and/or 500 telephone surveys.

The second assessment is the Forces of Change assessment. This assessment is done in one town hall-style meeting to capture the community's perception of current trends affecting the health of the community.

North Central Community Care Partnership (NCCCP) conducted a "Forces of Change" session. NCCCP members brainstormed what forces of change exist outside of the control of individuals in their communities. These are the things that affect the local health system of the community. They looked at social, economic, political, technological, environmental, scientific, legal and ethical issues. The group discussed the trends, events and factors that affect the community and identified a significant number of forces of change:

- Insurance issues
- Health reform
- Lack of medical specialists
- Lack of understanding rural issues
- Population isolation
- Loss of jobs
- Technology gaps
- Pipeline
- Water issues
- Government regulations
- Change in moral values
- Air quality issues
- Noise pollution
- Skin cancer
- Grant and budget cuts
- Lack of affordable quality housing
- Lack of activities for youth

- Increasing elderly population
- Migration of gangs and increasing drug issues
- Language barriers
- Outside corporations buying land
- Community apathy
- Increase in natural disasters
- Cost of gasoline
- Merging of school systems
- Decreasing retirement resources
- Higher taxes
- Disposable society
- Increase of on-line education
- Loss of social skills
- Cyber bullying
- Decreasing sense of accountability
- Lack of trust and respect
- Lack of dollars to improve structure of older buildings

The third assessment is the Community Health Status Assessment. This assessment provides data from the federal government (such as Census data), state (such as vital statistic data), and NCDHD as a district health department (such as immunization rates for the district or parental views on substance abuse). Data gathered for compilation came from many sources, including national surveys such as the Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, US Census, and Youth Protective Factor Survey. In total there are around 30 sources of data: community profiles, access to health care/quality of life, mental health, physical health, health risk factors, social programs, and crime. Data collected represents every age group from prenatal to elderly.

Community Involvement

The MAPP process currently underway is the most thorough assessment to date, and involves the most participants to date with more than 100 individuals participating thus far. This number does not include the 1,000 individuals surveyed or those who took part in focus groups.

Community Health Needs Assessment

To accomplish the health and quality of life improvement goal, community health surveys were distributed to 5,000 randomly selected households (proportionate to county population) in north-central Nebraska. This household health survey reveals information about the health and risk behaviors of the residents of the study area that is not available from other sources. It also allows the NCDHD to look at sub-groups within the area to identify groups with the greatest need. The survey was initially sent to selected households via two mailings of postcards and provided the option for selected participants to take the survey online. A second set of mailings was sent to the group of randomly

selected households. This mailing provided a hard-copy survey to complete with return postage paid, and excluded those households that had already completed the survey online. 1,774 completed surveys were recorded for an overall response rate of 35%.

MAPP process adapted from previous iterations

In the past, NCDHD completed community health needs assessments, community health improvement plans and NCDHD strategic plans every five years. The first cycle was completed in 2000 and the second cycle in 2006. This planning process has been essential in driving forward the work of the department and the strategic plans have been actively and regularly reported on to the governing board of NCDHD. This third MAPP process differs significantly from the first two processes in many ways. While NCDHD was due for a repeat of the three tiered process in 2012, the process will now occur every three years instead of every five years. This will require the department to become more efficient at the gathering of data for the Community Health Needs Assessment (CHNA). Previously, the entire cost of the CHNA has been borne by the NCDHD. For the current planning process, the local hospitals have shared in the planning and cost. While NCDHD has always worked with district hospitals as one of many planning partners on past CHIP efforts, this is the first time hospitals shared a responsibility with NCDHD for the development and implementation of the CHIP plans. In the past, the primary ownership of the CHIP rested with the NCDHD. Ownership of the plan is now shared between district hospitals and NCDHD, with NCDHD maintaining primary ownership and serving as a collaborative partner and technical consultant.

Special knowledge or expertise for MAPP and CHIP processes

Roger Wiese, the NCDHD Executive Director, has participated in a national effort to strengthen and transform public health through Collaboration for a New Century in Public Health: Turning Point Collaborative. NCCCP has been recognized by the National Association of City and County Health Officials (NACCHO) for the collaborative role they have played in the advancement of public health assessments. NCCCP was part of 41 communities awarded support from NACCHO, the Robert Wood Johnson Foundation and the W.K. Kellogg Foundation to develop a Turning Point: A New Collaboration In Public Health. This process was completed in March, 2003.

5. COMMUNITY DESCRIPTION AND DEMOGRAPHIC DATA

5A. OVERALL DISTRICT DEMOGRAPHICS

The community of North Central District Health Department is located in a very rural area in the north-central region of Nebraska. Our community outreaches throughout a 14,455 square mile area and includes the nine counties of Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce and Rock.

There are an estimated 45,135 people living in this north-central Nebraska community, allowing this area population to commune as 3.1 people per square mile. The median age of the people in our community is 45.6 years, and consists of mostly White at 88.3%, followed by 8.4% Hispanic or Latino and 4.3% Black or African American.

The median household income of our rural community is $37,938 and the per capita income is $28,482. The educational attainment level of the people here is at 88.5% as high school graduates for the percent of persons age 25+ and the percent of persons with less than a 9th grade education is at 7.7% in this community.

Other interesting facts:

- The land area of the district comprises one-fifth (19%) of the land area of Nebraska, while their population is 2.5% of the state population.
- Like much of rural Nebraska, the population in the district is declining, 11.4% in the last decade, and it is aging.
- Nearly one-third of the health district population is in the 45-64 age demographic, compared to 25% for Nebraska.
- One in five persons in the district is over the age 65 (NCDHD, 20%; NE, 13%).
- Just under half (49%) of the health district population is under the age 45, compared to nearly two-thirds (61%) for Nebraska.

2010 North Central District Health Department
Behavioral Risk Factor Web Query System - Nebraska

Indicators		Yes	No
Ever had sigmoidoscopy/ colonoscopy?	% CI n	**52.5** (48.3% - 56.8%) 318	**47.5** (43.2% - 51.7%) 292
Respondents aged 50 or older that have had a sigmoidoscopy or colonoscopy.	% CI n	**52.6** (48.4% - 56.9%) 318	**47.4** (43.1% - 51.6%) 291
Respondents aged 50+ that have had a blood stool test within the past two years.	% CI n	**13.9** (11.0% - 16.8%) 85	**86.1** (83.2% - 89.0%) 514
Ever had PSA Test?	% CI n	**69.2** (63.2% - 75.2%) 204	**30.8** (24.8% - 36.8%) 77
Ever told you have prostate cancer?	% CI n	**6.8** (4.0% - 9.6%) 24	**93.2** (90.4% - 96.0%) 262
Ever had digital rectal exam?	% CI n	**65.1** (59.1% - 71.1%) 191	**34.9** (28.9% - 40.9%) 93
Have you ever had a mammogram?	% CI n	**69.6** (63.3% - 75.8%) 417	**30.4** (24.2% - 36.7%) 107
Ever had a pap test?	% CI n	**95.3** (93.3% - 97.3%) 494	**4.7** (2.7% - 6.7%) 28

% = Percentage weighted to population characteristics, CI = 95% Confidence Interval for the Weighted Percentage, n = Non-Weighted Cell Size (numerator)
Denominator includes all respondents except those with missing, don't know/not sure, and refused answers

North Central District Health Department
Behavioral Risk Factor Web Query System - Nebraska

Ever told by doctor you have diabetes?			
		Yes	No
2007	% CI n	**8.9** (6.4% - 11.4%) 63	**89.6** (86.9% - 92.2%) 493
2008	% CI n	**8.9** (6.8% - 11.1%) 83	**89.7** (87.4% - 91.9%) 753
2009	% CI n	**8.2** (6.4% - 10.0%) 93	**88.8** (86.6% - 91.0%) 741
2010	% CI n	**8.2** (6.4% - 10.1%) 92	**89.6** (87.4% - 91.7%) 765
% = Percentage weighted to population characteristics, CI = 95% Confidence Interval for the Weighted Percentage, n = Non-Weighted Cell Size (numerator) Denominator includes all respondents except those with missing, don't know/not sure, and refused answers			

Comparison Table for
North Central District Health Department and Nebraska

Indicators	North Central District HD	Nebraska
Prevalence of high blood pressure – adults (2005)	22%	26.8%
Prevalence of high blood pressure – adults (2007)	22.5%	25.4%
Prevalence of high blood pressure – adults (2009)	23.5%	25.5%
Percent of adults aged 18+ with high blood cholesterol level (2007)	25.5%	31.9%
Percent of adults aged 18+ with high blood cholesterol level (2009)	32.7%	32.2%

Source: Nebraska Department of Health and Human Services, Community Health Assessment, 2010

Summary Table for North Central District Health Department 2009-2010

	Overall						Men						Women					
		LHD			State			LHD			State			LHD			State	
Indicators	**%**	**L %**	**U %**	**%**	**L %**	**U %**	**%**	**L %**	**U %**	**%**	**L %**	**U %**	**%**	**L %**	**U %**	**%**	**L %**	**U %**
Health Care Access																		
No health care coverage, 18-64 years old	18.4	15.5	21.2	15.8	14.6	17.1	18.2	13.9	22.4	16.6	14.7	18.4	18.5	14.8	22.2	15.1	13.4	16.8
Could not see a doctor in past year due to cost	9.2	7.6	10.9	10.9	10.0	11.7	4.6	2.6	6.5	9.2	8.0	10.4	13.7	11.1	16.3	12.5	11.2	13.7
Visited a doctor for a routine checkup in past year	58.2	55.3	61.1	58.0	56.8	59.3	52.4	47.8	57.0	51.3	49.4	53.2	63.8	60.4	67.2	64.5	63.0	66.1
Cardiovascular Disease																		
Ever told had a heart attack	4.7	3.7	5.6	3.7	3.4	3.9	5.9	4.3	7.5	4.9	4.5	5.3	3.5	2.4	4.6	2.5	2.2	2.7
Ever told had angina or coronary heart disease	5.3	4.2	6.4	3.9	3.5	4.2	6.0	4.2	7.9	4.6	4.2	5.0	4.7	3.4	5.9	3.1	2.7	3.6
Ever told had a stroke	2.3	1.6	2.9	2.3	2.1	2.6	1.9	1.0	2.8	2.3	1.9	2.7	2.6	1.7	3.6	2.4	2.1	2.7
Ever told blood pressure was high	29.6	26.2	33.0	27.1	25.9	28.4	28.3	23.0	33.6	29.0	26.9	31.1	30.8	26.5	35.0	25.3	23.9	26.7
Had cholesterol level checked during past 5 years	75.9	72.1	79.7	73.9	72.1	75.6	75.7	69.9	81.5	72.0	69.3	74.7	76.1	71.1	81.0	75.7	73.4	77.9
Ever told cholesterol was high, among screened	39.8	35.7	43.9	37.4	35.8	39.0	37.0	30.5	43.6	39.7	37.1	42.3	42.4	37.4	47.4	35.3	33.4	37.2
Diabetes																		
Ever told had diabetes	8.2	6.9	9.5	7.6	7.1	8.0	7.6	5.7	9.5	7.9	7.2	8.6	8.8	7.1	10.5	7.3	6.7	7.8
Overweight and Obesity																		
Overweight (BMI=25.0-29.9)	41.1	38.1	44.1	37.0	35.8	38.1	49.6	45.0	54.2	43.6	41.7	45.4	32.7	29.1	36.3	30.4	29.0	31.8
Obese (BMI=30+)	26.6	24.2	29.1	28.1	27.0	29.1	26.0	22.2	29.9	30.4	28.8	32.1	27.2	24.1	30.3	25.7	24.4	27.0
Fruit / Vegetable Consumption																		
Consumed fruits and vegetables 5+ times per day	23.9	20.5	27.3	21.1	19.8	22.4	18.5	13.6	23.4	15.7	14.0	17.5	29.1	24.7	33.5	26.1	24.3	28.0
Physical Activity (PA)																		
No leisure-time PA in past 30 days	30.7	28.1	33.2	24.5	23.5	25.4	31.4	27.4	35.4	23.1	21.7	24.5	30.0	26.8	33.1	25.8	24.5	27.1
Moderate or vigorous PA in a usual week	44.2	40.2	48.3	47.8	46.1	49.5	45.4	39.2	51.6	48.7	46.1	51.4	43.2	38.2	48.1	46.9	44.7	49.0
Vigorous PA 20+ min/day, 3+ days per week	25.2	21.3	29.1	29.7	28.0	31.4	27.2	21.3	33.1	31.9	29.2	34.5	23.2	18.7	27.8	27.6	25.4	29.8
Alcohol Consumption / Tobacco Use																		
Engaged in binge drinking in the past 30 days	18.0	15.4	20.5	18.7	17.6	19.7	25.5	21.0	30.0	25.2	23.5	26.9	10.8	8.5	13.2	12.5	11.3	13.7
Current smoker (at least some days of the month)	12.9	10.8	14.9	17.0	16.0	18.0	14.2	10.8	17.5	18.4	16.9	19.9	11.6	9.4	13.9	15.6	14.3	16.9
Attempted to quit smoking in past 12 months	54.4	46.5	62.4	56.6	53.4	59.8	53.4	41.4	65.4	54.6	49.9	59.2	55.6	45.4	65.9	59.0	54.7	63.2
Cancer Screening																		
Had a colonoscopy in past two years, 50+	10.4	8.3	12.6	11.8	11.0	12.7	10.8	7.1	14.5	13.1	11.7	14.6	10.1	7.7	12.6	10.7	9.7	11.7
Ever had a prostate cancer screening, male 50+	.	.	.	.	.	.	9.0	5.9	12.2	6.8	5.8	7.8	.	.	.	.	.	.
Had a mammogram in past two years, female 40+	.	.	.	.	.	.	.	.	.	.	.	.	68.3	63.7	72.8	71.5	69.9	73.2
Had a Pap test in past three years, female 18+	.	.	.	.	.	.	.	.	.	.	.	.	62.7	58.1	67.3	73.2	71.2	75.1

Note: % is weighted by health district, gender, and age; L% and U% are the lower and upper limits for the 95% confidence interval, respectively.

LHD=local/district health department; BMI=body mass index

Source: Nebraska Department of Health and Human Services Behavioral Risk Factor Surveillance System

North Central District Health Department
Comparison for Leading Causes of Death, 2008, 2009, 2010

2008 Comparison Table for North Central District Health Department and Nebraska		
Indicators	**NCDHD**	**Nebraska**
Cancer	165.9	171.9
Heart Disease	142.4	163.1
Coronary Heart Disease	79.2	87
Unintentional Injury	59	36.7
Chronic Obstructive Pulmonary Disease	37.5	51.2
Lung Cancer	36.3	45.5
Source: Nebraska Department of Health and Human Services, 2008		

2009 Comparison Table for North Central District Health Department and Nebraska		
Indicators	**NCDHD**	**Nebraska**
Heart Disease	173.1	152.9
Cancer	161.5	167.7
Coronary Heart Disease	98.2	83.8
Unintentional Injury	70.6	35.8
Lung Cancer	48.4	45.2
Stroke	47	40.3
Source: Nebraska Department of Health and Human Services, 2009		

2010 Comparison Table for North Central District Health Department and Nebraska		
Indicators	**NCDHD**	**Nebraska**
Cancer	166.6	167.4
Heart Disease	133	153.6
Coronary Heart Disease	72.4	85
Stroke	58	40.5
Unintentional Injury	48.8	35.5
Lung Cancer	46.5	46
Source: Nebraska Department of Health and Human Services, 2010		

North Central District Health Department
Morbidity and Mortality – Cancer Comparison Charts, 2004-2008

Cancer Incidence
Number of Cases and Rates, All Sites and Selected Primary Sites, by Place of Residence
Nebraska and North Central District Health Department Regions (2004-2008)

Cancer Sites	Nebraska		NCDHD	
	Number	Rate	Number	Rate
All Sites	44,995	482.2	1,572	475.7
Lung & Bronchus	6,074	65.3	209	58.5
Female Breast	6,172	125.3	213	131.0
Colon & Rectum	5,265	55.4	206	59.1
Prostate	6,628	158.0	302	192.0
Urinary Bladder	2,020	21.2	70	19.4
Non-Hodgkin Lymphoma	1,929	20.6	59	17.7
Leukemia	1,353	14.4	43	14.2
Kidney & Renal Pelvis	1,481	15.9	46	14.1
Melanoma	1,624	17.8	47	15.2
Uterine Corpus & Unspecified	1,317	26.3	35	20.3

*December 2011, Nebraska Department of Health and Human Services/Cancer Registry
Rates are per 100,000 population (excluding gender-specific sites, which are per 100,000 male or female population) and are age-adjusted to the 2000 U.S. population

Cancer Mortality
Number of Deaths and Rates, All Sites and Selected Primary Sites, by Place of Residence
Nebraska and North Central District Health Department Regions (2004-2008)

Cancer Sites	Nebraska		NCDHD	
	Number	Rate	Number	Rate
All Sites	16,902	175.7	613	164.3
Lung & Bronchus	4,507	48.0	170	46.9
Female Breast	1,181	22.0	28	▽ 14.4
Colon & Rectum	1,854	18.8	87	22.4
Prostate	955	24.9	38	22.9
Urinary Bladder	397	4.0	13	3.0
Non-Hodgkin Lymphoma	707	7.2	21	5.4
Leukemia	705	7.3	21	5.5
Kidney & Renal Pelvis	428	4.5	11	3.3
Melanoma	283	3.0	4	**
Uterine Corpus & Unspecified	273	5.0	14	6.2

*December 2011, Nebraska Department of Health and Human Services/Cancer Registry
Rates are per 100,000 population (excluding gender-specific sites, which are per 100,000 male or female population) and are age-adjusted to the 2000 U.S. population
**Rate not shown if based on five or fewer events
▽ Regional rate is significantly lower than the state rate (99% confidence level)

5B. COUNTY-SPECIFIC DEMOGRAPHICS

North Central District Health Department Community Demographics									
County	**Population**	**Population by Gender Male**	**Population by Gender Female**	**Population Density**	**Median Age**	**Population Age: 0-24**	**Population Age: 25-64**	**Population Age: 65-84**	**Population Age: 85+**
Antelope	6,652	3,294	3,358	7.7	45.0	2,127	3,146	1,121	258
Boyd	2,063	1,002	1,061	3.9	46.9	566	994	408	95
Brown	3,062	1,515	1,547	2.5	47.5	859	1,477	588	138
Cherry	5,474	2,744	2,730	0.9	42.9	1,682	2,773	842	177
Holt	10,011	4,922	5,089	4.2	45.5	3,227	4,731	1,651	402
Keya Paha	802	395	407	1	45.4	231	389	153	29
Knox	8,378	4,089	4,289	7.6	45.5	2,620	3,886	1,488	384
Pierce	7,184	3,623	3,561	12.5	41.5	2,467	3,574	931	212
Rock	1,509	741	768	1.5	50.2	382	789	272	66
NCDHD	45,135	22,325	22,810	3.1	45.6	14,161	21,759	7,454	1,761
Nebraska	1,796,619	891,652	904,967	23.8	36.2	648,434	907,555	201,086	39,544
Data source: Community Health Assessment Measures, 2010, Nebraska Department of Health and Human Services									

North Central District Health Department

Morbidity and Mortality – Cancer Comparison Charts, 2004-2008

Cancer (all sites) Incidence Number of Cases and Rates, by County of Residence				
	2008		2004-2008	
Residence	# Cases	Rate	# Cases	Rate
United States	1,388,340	462.9	6,954,645	472.4
Nebraska	8,930	465.3	44,995	482.2
Antelope County	50	523.9	210	454.7
Boyd County	13	449.6	77	449.2
Brown County	14	278.1	111	435.4
Cherry County	41	564.7	194	504.2
Holt County	59	433.3	362	488.5
Keya Paha County	6	407	32	455.1
Knox County	58	467.8	318	484.4
Pierce County	44	509.5	207	471.5
Rock County	13	720.9	61	553.7

*December 2011, Nebraska Department of Health and Human Services/Cancer Registry

Cancer (all sites) Mortality Number of Deaths and Rates, by County of Residence				
	2008		2004-2008	
Residence	# Cases	Rate	# Cases	Rate
United States	562,867	178.1	2,792,520	183.8
Nebraska	3,377	171.6	16,902	175.7
Antelope County	19	183.2	78	147.6
Boyd County	5	**	27	128.1
Brown County	4	**	42	144.6
Cherry County	16	199.9	70	165.9
Holt County	27	159.4	135	159.4
Keya Paha County	3	**	9	124.7
Knox County	28	185.8	142	190.3
Pierce County	18	190.4	88	194.2
Rock County	2	**	22	152.5

*December 2011, Nebraska Department of Health and Human Services/Cancer Registry

**Rate not shown if based on five or fewer events

North Central District Health Department
Maternal Child Health

Live Births, Infant Mortality and First Trimester Prenatal Care, by County of Residence				
	Total Live Births	**Teen Births as % of Live Births**	**Infant Mortality**	**Incidence of Preterm Birth**
Residence	Total Number 2005-2009	% of Total Live Births 2005-2009	Rate 2005-2009	% of Births 2005-2009
Nebraska	133,723	8.35	5.75	9.75
NCDHD	2,644	6.2	6.05	8.21
Antelope County	414	4.83	9.66	7.25
Boyd County	84	4.76	0	10.71
Brown County	136	4.41	0	7.35
Cherry County	331	10.27	3.02	10.57
Holt County	621	4.83	6.44	7.73
Keya Paha County	43	4.65	23.26	13.95
Knox County	506	7.91	5.93	8.1
Pierce County	433	5.54	4.62	7.39
Rock County	76	5.26	13.16	7.89

Source: Nebraska Department of Health and Human Services/Community Health Assessment, 2005-2009

North Central District Health Department
Leading Diagnoses for Area Hospital Discharges, 2012

Brown County Hospital — Ainsworth, Nebraska

1. **Weakness, Fatigue**
2. **Pneumonia**
3. **Aftercare Following Surgery**
4. **Cerebral Artery Occlusion**
5. **Congestive Heart Failure**

West Holt Memorial Hospital — Atkinson, Nebraska

1. **Hypertension**
2. **Coronary Artery Disease**
3. **Diabetes**
4. **Atrial Fibrillation**
5. **Congestive Heart Failure**

Rock County Hospital — Bassett, Nebraska

1. **Pneumonia**
2. **Congestive heart failure**
3. **Chest pain Not Otherwise Specified**
4. **Dizziness**
5. **Malaise/fatigue**

Avera Creighton Hospital — Creighton, Nebraska

1. **Pneumonia**
2. **Dehydration**
3. **Urinary Tract Infection**
4. **Bowel Obstruction**
5. **Cellulitis**

Niobrara Valley Hospital	Lynch, Nebraska
1. Pneumonia 2. Bronchial Pneumonia 3. Gastroenteritis 4. Diabetes Mellitus 5. Syncope	

Antelope Memorial Hospital	Neligh, Nebraska
1. Pneumonia 2. New Born 3. Cellulitis of the Lower Extremity 4. Gastroenteritis 5. Influenza	

Avera St. Anthony's Hospital	O'Neill, Nebraska
1. Pneumonia 2. Urinary Tract Infection 3. Chronic Obstructive Pulmonary Disease Exacerbation 4. Newborn Delivery 5. Dehydration	

Osmond General Hospital	Osmond, Nebraska
1. Pneumonia 2. Dehydration 3. Congestive Heart Failure 4. Chronic Obstructive Pulmonary Disease Exacerbation 5. Abdominal Pain	

Alegent Creighton Health – Plainview Hospital Plainview, Nebraska
1. Chronic Obstructive Pulmonary Disease with Acute Exacerbation 2. Pneumonia 3. Cellulitis 4. GI Bleed

Tilden Community Hospital	Tilden, Nebraska
1. Chest Pain 2. Pneumonia 3. Congestive Heart Failure/ Chronic Obstructive Pulmonary Disease 4. Status Post Total Hip Replacement	

Cherry County Hospital	Valentine, Nebraska
1. Obstetrics 2. New Born 3. Pneumonia 4. Chronic Obstructive Pulmonary Disease	

6. DATA ANALYSIS, PUBLIC HEALTH DATA AND INDICATORS

North Central District Health Department contracted with Dr. Joseph Nitzke, PhD of Ionia Research, to review and publish an analysis of the district's data. The "Report Analysis and Comments Public Health Data (PHAN)" document has been prepared for NCDHD using Public Health Agencies of Nebraska (PHAN) data as the primary source. The intent is to summarize trends in data and differences between the counties served by NCDHD and the rest of the state of Nebraska.

The observations within the report are based on the application of formulas to evaluate "dependent crude rates/ratios" (Crude Rate Analysis), comparing the NCDHD district rates or percentages for an indicator with those of the state to determine whether or not those differences are significant. These observations are also placed in the context of other reports where appropriate, including the Behavioral Risk Factor Surveillance System (BRFSS 2007-2008), the 2005 Data Book produced by the Nebraska Health Information Project, prior assessments, and state profiles.

7. COMMUNITY INVOLVEMENT

Involvement of community members from several entities was key to the success of the overall process and plan development. An effort was made to involve community members during each step of the planning process. Entities that were invited to meetings included hospitals, physicians, dentists, community action agencies, law enforcement, social services, mental health providers, senior care services, schools, media, city/county officials, representatives of minority populations, clergy, Nebraska Department of Health and Human Services and other community-based services. The community members were contacted via mail, email and telephone prior to each step of the process to invite and encourage their participation in the planning process.

Organizations that participated in the CHIP meeting, community focus group meetings and strategic planning sessions are listed below. These entities had one or more participants in the process.

- Ainsworth Community Schools
- Alegent Creighton Health/Plainview
- Antelope County Supervisors
- Antelope Memorial Hospital
- AseraCare
- Avera Creighton Hospital
- Avera St. Anthony's Hospital
- Avera St. Anthony's Mission Services
- Boyd County Ambulance
- Boyd County Sheriff's Department
- Bright Horizons
- Brown County Hospital

- Building Blocks and Counseling Enrichment
- Cherry County Hospital
- Cherry County Sheriff's Department
- Central Nebraska Community Services
- Counseling & Enrichment Center
- Creighton Community School
- Dietician
- Early Development Network
- Emmanuel Lutheran Church – Tilden
- Faith Regional Health Services
- Heartland Counseling
- Jacy's Grace Home Health
- Mayor of O'Neill
- North Central Community Cares Partnership
- North Central District Health Department
- NCDHD Board of Health members
- Nebraska Department of Health and Human Services
- Nebraska State Patrol
- Niobrara Valley Hospital
- O'Neill Police Department
- O'Neill Public Schools
- Osmond General Hospital
- Pierce County Commissioner
- Prairie View Assisted Living
- Region 24 Emergency Management
- Region 4 Behavioral Health System
- Rock County Hospital
- Santee Health Clinic
- St. Mary's High School
- Tilden Community Hospital
- Trinity Lutheran Church
- UNL Extension in the Brown-Keya Paha-Rock counties
- Valentine Dental Clinic
- West Holt Memorial Hospital
- Community members / by invite

8. COMMUNITY HEALTH IMPROVEMENT PLANNING

8A. OCTOBER 2012 MEETING

A Community Health Improvement Planning meeting was held on October 12, 2012 at the O'Neill Country Club. The purpose of this meeting was to pull together a diverse group of individuals from several entities representative of our nine county district to review the data for the district, which included the community health needs assessment and secondary data from multiple assessment sources. Participants referred back to the data (see appendix) that was presented as they engaged in the strategic planning process. Dr. Joe Nitzke of Ionia Research provided an executive summary of the community health assessment and the secondary data. Deb Burnight of Burnight Facilitated Resources facilitated the process of identifying focus areas and priority issues, and guided the strategic planning sessions in the afternoon.

Community members were invited to this planning meeting via email through a list developed in the NCDHD database. Entities that attended included: NCDHD, NCCCP, NCDHD Board of Health members, UNL Extension in the BKR counties, Avera St. Anthony's Hospital, Alegent Creighton Health/Plainview, Region 4 Behavioral Health System, CNCS, Osmond General Hospital, Heartland Counseling, Region 24 Emergency Management, Antelope Memorial Hospital, Early Development Network, Brown County Hospital, Niobrara Valley Hospital, Bright Horizons, O'Neill Public Schools, Tilden Community Hospital, Nebraska State Patrol, Antelope County Supervisors, West Holt Memorial Hospital, Building Blocks and Counseling Enrichment, Faith Regional Health Services, AseraCare, Nebraska Department of Health and Human Services, and Jacy's Grace Home Health.

The agenda for the CHIP meeting was:

- Registration
- Welcome & introductions
- Presentation of executive summary and secondary data
- Focus areas determined
- Priorities developed for each focus area
- Strategic planning group sessions
- Adjourn

Following the time for networking, registration and breakfast, Roger Wiese, Executive Director for North Central District Health Department welcomed the participants to the session and provided background information about the CHIP process. Participants also introduced themselves and the agencies that they represented. Joe Nitzke was introduced and provided an overview of the community health assessment executive summary, which was emailed to invitees prior to the meeting, as well as secondary data that included selected data from community surveys, PHAN, BRFSS and Vital Statistics. Participants were provided with a worksheet so that during the presentation they could list major health problems or high-risk behaviors that were noticed and how the data to show these problems/behaviors were an issue.

After the data set was presented (see appendix), the entire group of participants worked together listing the issues they felt to be most important. Each table would decide upon the top five most critical priorities based on the data presented, the conversations they had been having throughout the day and the focus areas. A "sticky wall" was utilized during the process and every table brought their priorities to the "sticky wall". Once all priorities were on the wall, the group was able to identify common issues. All of the common issues were then placed together on the wall.

Participants at each table talked through the priorities listed on the wall and determined how they would prioritize the issues that were listed. Prioritization was based on issues that are doable/achievable, issues that address a critical need, resource availability – both human and financial, and those that could provide a community focus. Each participant was given dot stickers and asked to place their dots on the issues that were of the most concern to them.

A discussion was held about how many strategic areas the CHIP group could manage effectively. The participants then decided to choose five focus areas around which to mobilize collaborative action over the next three years (with the understanding that other issues may be able to feed into the priority issues) or may be chosen in three years when the next planning process occurs.

IDENTIFIED PRIORITY NEEDS

In general, the CHIP group felt that it was important to not lose any of the priority issues, too many areas may dilute the entire process and make it less effective. The group determined that four broad focus areas would be adequate to cover the major health problems and high-risk behaviors discussed, and several priorities would be listed within each focus area. The identified community health needs led to the creation of the following focus areas (priorities related to each focus area are listed below the respective heading):

Access to Care / Cancer Prevention and Education

- **Access to affordable health care**
- **Health care for all**
- **Flu vaccination (general)**
- **Rx assistance**
- **Immigrant population**
- **Dental care**
- **Vision**
- **Colon cancer**
- **Colorectal screening**
- **Prostate screening**
- **Need increased mammography screening**
- **Preventative screening across all cancers**

Behavioral Health – Mental Health and Substance Abuse

- **Stress management**
- **Lack of mental health services and payment**
- **Mental health access**
- **Mental health (providers, awareness, low reimbursement)**
- **Tobacco use**
- **Alcohol use across lifespan**
- **Alcohol (Youth)**
- **Substance abuse – alcohol (binge), prescription drugs, tobacco**
- **Binge drinking**

Chronic Disease, Obesity, and Related Health Concerns

- **Cardiovascular, heart disease, stroke**
- **Cardio, CPR, response time, education, confusion**
- **Lack of exercise**
- **Weight issues (BMI)**
- **Over-weight & obesity**

Environment & Safety

- **Bike helmet usage**
- **Farm / agriculture safety**
- **Texting and driving**
- **Child safety seats**
- **Radon**
- **Domestic violence and child abuse**
- **Environmental issues in community**

Once the focus areas were decided upon, individuals selected a focus area that was of interest to them and the larger group then divided up into focus area groups. Each table focused on their topic of interest and associated priorities. The groups listed current resources to address the priorities, completed a gap analysis to identify where there were gaps and listed the benefits of addressing the priorities.

Prior to adjourning, it was discussed that community focus group meetings would be held in December and January to determine if there were other issues community members were aware of that needed to be addressed in the strategic planning sessions.

NEEDS RECOGNIZED BUT NOT ADDRESSED

Although NCDHD recognizes the importance of all needs identified by the community, NCDHD will not directly design strategies for all issues in the community health needs assessment. These needs, while important to the health system and the community, were not chosen based on our community prioritization. Prioritizing examined the severity of the problem and the health system's ability to impact the issue.

The following will not be addressed due to the low priority status compared to chosen goals:

- Youth consumption of energy drinks
- Depreciated family values and morals
- Safety in schools
- Youth internet access
- Foodborne illness
- Opposing legalization of marijuana

The health system does not feel adequate resources, funding, or data are available to take on the following projects at this time:

- Elderly prescription education, medication management
- Emergency Protective Custody (EPC) issues
- Insurance concerns- premium affordability, Medicaid/ Medicare funds being cut
- Elderly long-term care financial burden
- Lack of safe, affordable housing

If the health system is made aware of other programs and resources in the community to address these issues, we will continue to provide our support to effectively meet the community health needs.

8B. NOVEMBER 2012 – JANUARY 2013 COUNTY FOCUS GROUP MEETINGS

The next step in the planning process was to conduct county focus group meetings. Ten (10) meetings were held between November 2012 and January 2013. Invitations were sent to attendees of the October 2012 meeting, along with other community members from each specific county. A written invitation was sent, followed by emails and phone calls.

The agenda for the county focus group meetings was:

- Introductions
- Past planning meetings
- Executive summary of Community Health Assessment Survey
- Secondary Data Executive Summary
- Community Health Improvement Plan
- Priorities
- Next Steps

County meetings were held on the following dates:

- Knox County – November 26, 2012
- Holt County – O'Neill – November 27, 2012
- Antelope County – Tilden – December 17, 2012

- Antelope County – Neligh – December 17, 2012
- Cherry County – December 18, 2012
- Brown County – December 18, 2012
- Boyd County - December 19, 2012
- Holt County – Atkinson – December 19, 2012
- Pierce County – December 20, 2012
- Rock County – January 10, 2013

Introductions were completed at each county focus group meeting. Roger Wiese, Executive Director with North Central District Health Department discussed the past planning efforts and how NCDHD had gotten to the point of conducting county focus group meetings. An executive summary and secondary data summary were presented and discussed. Information that was developed at the October 2012 CHIP meeting was presented and attendees from each county discussed other topics they felt were evident in their communities. These additions and comments were placed into documents and a summary was developed to use in future planning efforts. See appendix for county focus group meeting notes.

8C. FEBRUARY – MARCH 2013 STRATEGIC PLANNING SESSIONS

Following the community health improvement planning meeting held in October 2012 and county focus group meetings held from November 2012 through January 2013, CHIP strategic planning sessions were held at the Blarney Stone restaurant on February 8 and March 7, 2013.

The agenda for these meetings included the following items:

1. Introductions
2. Overview
   a) History and purpose of community health assessment
   b) Summary of planning process thus far
   c) Development of SMART goals leading to objectives and action planning
3. Next steps
   a) Ongoing planning, creating objectives and action items

During these meetings, participants were updated with the process so far. This included a recap of the October CHIP meeting, during which participants chose areas of focus; followed by a recap of county focus group meetings. The February 8 meeting addressed the focus areas of Chronic Disease, Obesity, and Related Health Concerns and Behavioral Health – Substance Abuse and Mental Health. The meeting on March 7 addressed the focus areas of Access to Care / Cancer Prevention and Education and Environment and Safety. Data sheets with state and district data and Healthy People 2020 Objectives were provided for each focus area. Each group reviewed the data and began the process of forming goals and objectives for the public health system. The workgroups were asked to articulate goals, determine the baseline of data to support the need for the goal, and develop SMART (Specific, Measureable, Achievable, Realistic, Time-Bound) objectives. The challenge for each group was to

consider the focus area in terms of the entire nine (9) counties rather than setting goals and objectives specific to a county or facility. Participants in each focus area discussed how they would choose the priority issues, agreeing to participate in subsequent meetings to accomplish this and further develop key strategies and activities. These meetings will be accomplished via Telehealth, telephone conference calls and/or face to face meetings. Workgroups will accomplish their work independently of the large group, with each group determining the frequency they will meet to keep the plan moving forward. Additional work completed by these groups to fine-tune objectives and establish action items will address policy change. Workgroups are encouraged to meet at least quarterly to continue planning and progress updates. The workgroups will be led by NCDHD staff and community partners. Participants are encouraged to invite other key individuals that may be interested in the focus area and bring additional perspective.

Work groups at the February and March strategic planning sessions were established by asking participants to choose their focus area of interest. Work group members, along with goals and objectives identified for each focus area are listed in the Implementation Plan section of this document.

GAP ANALYSIS

Strengths Identified in the NCDHD Community Include:

The greatest strength, and a driving force of the NCDHD area, is the partnership that exists between the hospitals in the region. Improving community health for all is important for achieving better lifestyles and beyond. A solid infrastructure is already in place to obtain the goals set forth in the Improvement Plan, and shared responsibilities between the entities in the community create a strong network of support.

Gaps Identified in the NCDHD Community Include:

The biggest community health issue our nine county district faces is the lack of available providers. As mentioned before, nine out of eleven counties in the district are Medically Underserved Areas (MUA). The Health Resources and Services Administration of the U.S Department of Health and Human Services give MUA designation when the Index of Medical Underservice (IMU) score is 62.0 or less. IMU uses the following four variables to create a score: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. In addition, the following table demonstrates the State of Nebraska's designations for Family Practice shortages as well as shortages for specialties in the NCDHD district.

The lack of consistent high quality relevant data is a challenge. In some areas there is good data, but in other areas it is not collected at all, or it is not collected in a way that is useable. Stigma concerning mental health issues will also be an obstacle to overcome, especially in the small town communities of the district. The expansive geographical nature of the district presents a challenge in achieving coordination between providers and providing adequate service to community members.

Nebraska Rural Health Advisory Commission State Designated Shortage Areas- Medical and Mental Health NCDHD Counties						
County Name	**Family Practice**	**General Internal Medicine**	**General Pediatrics**	**OB/GYN**	**General Surgery**	**Psychiatry & Mental Health**
Antelope	X	X	X	X		X
Boyd			X	X	X	X
Brown	X		X	X	X	X
Cherry	X	X	X	X		X
Holt	X	X	X	X	X	X
Keya Paha	X	X	X	X	X	X
Knox	X	X	X			X
Pierce	X	X	X	X		X
Rock		X	X	X	X	X

Table1.1 "blank" indicates county is not a shortage for that specialty, "X" indicates shortage area for that specialty

8D. NEXT STEPS

The Health Department has established individual teams to develop goals and implement strategies for each priority. Team leaders from the Health Department will be identified and commit to continued service on each of the priority area teams. Each team leader is responsible for:

- Organizing a team which includes both field professionals and representative community members.
- Guiding the work of the team, including development of goals, logic model and work plan.
- Establishing metrics including measurable outcomes indicators.
- Assuring work is coordinated with other priority teams.
- Communicating appropriately with the community at large.

9. IMPLEMENTATION PLAN

FOCUS AREA:	Access to Care / Cancer Prevention & Education

WORK GROUP TEAM MEMBERS	
NAME:	**ORGANIZATION:**
Bunner, Stephanie	North Central District Health Department
Cork, Ron	Avera St. Anthony's Hospital
Genovese, Jacque	Faith Regional Health Services
Green, Jack	Antelope Memorial Hospital
Hart, Peggy	North Central District Health Department
Johnson, Geri	Brown County Hospital
Kuester-Burtwistle, Tracy	Faith Regional Health Services
Miller, Shannon	Avera St. Anthony's Hospital
Morse, Ronald P	Avera Medical Group
Schulte, Mark	Avera Creighton Hospital
Sorensen, Shannon	Brown County Hospital

GOAL 1:	Increase the number of primary care physicians serving the NCDHD area.

Objective 1:	Increase the percentage of medical providers that utilize telemedicine options.
Baseline Data:	In NCDHD there are 1,206 persons per physician, compared to 434 persons per physician in Nebraska. Shortages include: 9 counties short in obstetrics/gynecology & psychiatrists; 8 short in pediatrics; 7 short in family practice & internal medicine; 6 short in general surgery; and 5 short in occupational therapy & pharmacy. Telemedicine is available in all hospitals, but is greatly underutilized.
Measurable Outcome:	By 2016, there will be a 15% increase in the number of physicians that utilize telemedicine options for patient treatment.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD has made our tele-health system available for mental health administrative training, e.g., with Magellan. Also have provided TESH. Resources have just been employee time and equipment, $150/event.	$150/event	Support our hospitals in this effort. NCDHD will also reach out to area providers informing them that we have tele-health system available.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**

Comments/Progress:			

Objective 2:	Secure an adequate level of reimbursement for telemedicine utilization.			
Baseline Data:	In NCDHD there are 1,206 persons per physician, compared to 434 persons per physician in Nebraska. Shortages include: 9 counties short in obstetrics/gynecology & psychiatrists; 8 short in pediatrics; 7 short in family practice & internal medicine; 6 short in general surgery; and 5 short in occupational therapy & pharmacy. Telemedicine is available in all hospitals, but is greatly underutilized.			
Measurable Outcome:				
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently does not provide resources to this.	$0	NCDHD will provide support in the form of policy development for our providers of direct health.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 2:	Increase the number of employers that offer incentives for investment in the employee's health in the NCDHD area.

Objective 1:	Increase the percentage of employers that offer worksite wellness programs.			
Baseline Data:	Unable to locate baseline data.			
Measurable Outcome:	By 2016, there will be a 25% increase in the number of employers that offer worksite wellness programs.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently manages a worksite wellness program to a few businesses in a few counties of our district. The program is mainly for technical assistance in setting up a wellness program.	$15,000/ year for grant aided by grant funds and $5,000/year of NCHD resources.	NCDHD will plan to establish technical assistance for worksite wellness in all the district's nine counties.	NCDHD will look at committing $5,000/year of resources, e.g., cash and in-kind.	NCDHD

Action Item:	Resources:	Responsibility:	Timeline:
Comments/Progress:			

GOAL 3:	Increase the health literacy of residents in the NCDHD area.

Objective 1:	Increase the proportion of persons who report their health care provider always gives them easy-to-understand instructions about what to do to take care of their illness or health conditions.
Baseline Data:	60% of persons reported that their health care providers always explained things so they could understand them in 2007
Measurable Outcome:	By 2016, 70% of persons will self-report that their health care provider always gives them easy-to-understand instructions about what to do to take care of their illness or health conditions.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not currently provide any services for this objective.	$0	NCDHD staff members assigned to focus area will work with other group members to determine action items for achieving this objective.	TBD	NCDHD/ Partners

Action Item:	Resources:	Responsibility:	Timeline:
Comments/Progress:			

GOAL 4:	Increase the percentage of children and adults who are vaccinated annually against seasonal influenza in the NCDHD area.

Objective 1:	Increase the percentage of pregnant women who are vaccinated against seasonal influenza.
Baseline Data:	No specific data for pregnant women in district.
Measurable Outcome:	By 2016, 80% of the pregnant women will be vaccinated against seasonal influenza.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
Currently, North Central District Health Department provides	$3,000.00-$5,000.00/ year	North Central District Health Department has developed a business plan to address	$75,000	NCDHD

education during influenza season regarding the importance of being vaccinated, via radio and newspaper Public Service Announcements. Influenza vaccination is also promoted through billboard advertisement throughout the 9-county district.		increasing the number of individuals within the health district who receive a yearly influenza vaccination by offering influenza vaccinations to businesses as worksite wellness, with the ability to bill insurance for the services provided. The health department concurrently plans to hold community immunization clinics for the influenza vaccination.		
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Increase the percentage of health care personnel who are vaccinated annually against seasonal influenza.			
Baseline Data:	No specific data for health care personnel in district.			
Measurable Outcome:	By 2016, 90% of health care personnel in the NCDHD district will be vaccinated against seasonal influenza.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
North Central District Health Department currently offers yearly influenza vaccination not only to healthcare personnel, but to all health department employees at no cost to employees.	$300.00/ year ($30.00/ employee)	North Central District Health Department will continue to offer influenza vaccinations to employees. The health department also plans to provide influenza vaccinations to residents within the 9-county health district via worksite clinics and community based influenza vaccination clinics.	$75,000	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 3:	Increase the percentage of children aged 6 months to 18 years who are vaccinated against seasonal influenza.
Baseline Data:	Data is not available on the percentage of children aged 6 months to 18 years who are vaccinated against seasonal influenza.
Measurable Outcome:	By 2016, 80% of the population aged 6 months to 18 years will be vaccinated against seasonal influenza.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
Currently, North Central District Health Department provides education during influenza season regarding the importance of being vaccinated, via radio and newspaper Public Service Announcements. Influenza vaccination is also promoted through billboard advertisement throughout the 9-county district.	$3,000.00-$5,000.00/ year	North Central District Health Department will continue to offer influenza vaccinations to employees. The health department also plans to provide influenza vaccinations to residents within the 9-county health district via worksite clinics and community based influenza vaccination clinics.	$75,000	NCDHD

Action Item:	**Resources:**	**Responsibility:**	**Timeline:**

Comments/Progress:	

Objective 4:	Increase the percentage of adults aged 18 – 64 years who are vaccinated against seasonal influenza. Increase percentage of adults' age 65+ years who are vaccinated against seasonal influenza.
Baseline Data:	Adult immunizations for influenza (74%) are significantly lower within NCDHD when compared to the state. Hospitalizations related to pneumonia and influenza are also higher when compared to the state. 24.9% of non-institutionalized adults aged 18-64 years received influenza vaccine for the 2008-09 influenza season
Measurable Outcome:	By 2016, 80% of the population aged 18-64 years will be vaccinated against seasonal influenza and 90% of the population 65+ will be vaccinated.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
Currently, North Central District Health Department provides education during influenza	$3,000.00-$5,000.00/ year	North Central District Health Department has developed a business plan to address increasing the number of	$75,000	NCDHD

season regarding the importance of being vaccinated, via radio and newspaper Public Service Announcements. Influenza vaccination is also promoted through billboard advertisement throughout the 9-county district.		individuals within the health district who receive a yearly influenza vaccination by offering influenza vaccinations to businesses as worksite wellness, with the ability to bill insurance for the services provided. The health department concurrently plans to hold community immunization clinics for the influenza vaccination.		
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 5:	Increase the percentage of adults who are vaccinated against pneumococcal disease.

Objective 1:	Increase the percentage of non-institutionalized adults age 65 years and older who are vaccinated against pneumococcal disease.			
Baseline Data:	60.1 percent of persons aged 65 years and older in 2009 had ever received a pneumococcal vaccination			
Measurable Outcome:	By 2016, 90% of non-institutionalized adults age 65 years and older will be vaccinated against pneumococcal disease.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently offer a service.	$0	NCDHD will consider adding the pneumococcal vaccine after evaluating the success of the implementation of the influenza vaccine program.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Increase the percentage of non-institutionalized high-risk adults aged 18 – 64 years who are vaccinated against pneumococcal disease
Baseline Data:	16.6 percent of high-risk persons aged 18 – 64 years in 2009 had ever received a

	pneumococcal vaccination			
Measurable Outcome:	By 2016, 60% of high-risk adults aged 18-64 years will be vaccinated against pneumococcal disease.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently offer a service.	$0	NCDHD will consider adding the pneumococcal vaccine after evaluating the success of the implementation of the influenza vaccine program.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 6:	Increase the percentage of children and adults who see a dentist yearly for preventive care in the NCDHD area.

Objective 1:	Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.			
Baseline Data:	Persons in the lowest income bracket, under $15,000, were more likely to report never having visited a dentist (27.9% vs. 3.7% of those in the highest income bracket). About 55% of respondents to the community health survey with incomes below $15,000 per year said they had visited the dentist within the last year compared to 76% of respondents earning $40,000 or more per year.			
Measurable Outcome:	By 2016, 65% of residents in NCDHD with incomes below $15,000 per year will have received preventative dental services during the past year.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently operates an on the road program where we go to schools who have responded to our invitation and provide screenings and fluoride varnish treatments to those youth clients who provide consent forms. NCDHD has been to nine schools (25% of total schools in district) in the	$31,000.	For the 2013 – 2014 school year, NCDHD plans to increase our school participation number to 25 schools (73%).	$41,000.	NCDHD

fall of 2012 and seventeen schools (50%) in the spring of 2013.				
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Increase the proportion of children, adolescents, and adults who used the oral health care system in the past 12 months.			
Baseline Data:	In the NCDHD study, the proportion of respondents who visited the dentist in the past 12 months was fairly constant (63.1% - 74.8%). 84% of children 3 and older have had a dental checkup in the past year.			
Measurable Outcome:	By 2016, increase the number of children, adolescents and adults who have visited a dentist in the past year to 85%.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD makes available on two days in the month, in the O'Neill clinic for Women, Infants and Children (WIC), an oral health screening and fluoride varnish treatment for children and adults.	$4,000/year	NCDHD will plan to continue this program, limited to the O'Neill Clinic location. NCDHD will plan to market this service more effectively through health literacy to increase participant numbers.	$5,000/year.	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 7:	Increase the percentage of men in the NCDHD area who visit their care provider for preventive care.

Objective 1:	Increase the proportion of men who have discussed with their health care provider whether to have prostate-specific antigen (PSA) testing and digital rectal exam (DRE) to screen for prostate cancer.
Baseline Data:	Incidence rates for prostate cancer (2003-2007) are 194.6 per 100,000 population and deaths due to prostate cancer (2005-2009) for NCDHD is at 25.7. Compared to the State of Nebraska the incidence rate is 158.9 and a death rate of 24.7. In the NCDHD survey, 74% of men over 40 years have ever been screened for prostate cancer.
Measurable Outcome:	By 2016, 80% of men over 40 years will self-report that they have discussed with their health care provider whether to have prostate-specific antigen (PSA) testing and digital

	rectal exam (DRE) to screen for prostate cancer.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD provides marketing in the form of public service announcements to the public.	$0	NCDHD will continue to run public service announcements in support of these screening interventions.	$0	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 8:	Increase the percentage of adults 50 years and older in the NCDHD area who are screened for colorectal cancer.

Objective 1:	Increase the percentage of adults who were counseled about colorectal cancer screening.			
Baseline Data:	Incidence rate for colorectal cancer (2003-2007) are 55.9 per 100,000 population and deaths due to colorectal cancer (2005-2009) for NCDHD is at 20.6. Compared to the State of Nebraska the incidence rate is 56.2 and a death rate of 18.2. In comparison with other states Nebraska rates in the top tier with the highest rates in incidence and deaths. Nebraska ranks 39th in the percent screened for colorectal cancer. In the NCDHD survey, 66% of those over 50 years report that they have been tested for colon cancer, with about half tested every 3 years or more.			
Measurable Outcome:	By 2016, 75% of those over 50 years will report they have been tested for colon cancer, with 43% tested every 3 years or more.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently gives information to people who receive free FOBT tests and information is available at health fairs.	$1,000	Provide education to health clinics/health providers regarding the importance of counseling patients 50 years and older about colorectal cancer screening.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 9:	Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines in the NCDHD area.

Objective 1:	Increase the number of women who self-report completing self-breast exams based on the most recent guidelines.
Baseline Data:	No specific baseline data for self-examination reporting. Incidence rates for breast cancer (2003-2007) are 118.5 per 100,000 population and deaths due to breast cancer (2005-2009) for NCDHD is 15.5. Compared to the State of Nebraska the incidence rate is 123.2 and a death rate of 21.2. For women 50+, 74.6% of survey respondents had a mammogram in the past 2 years. For women 40-50 years old in the Health District, 73.1% of survey respondents have had a mammogram in the past 2 years.
Measurable Outcome:	By 2016, 82% of women will self-report having completed a self-breast exam based on the most recent guidelines.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not provide a service at this time.	$0	NCDHD staff members assigned to focus area will work with other group members to determine action items for achieving this objective.	TBD	NCDHD/ Partners

Action Item:	Resources:	Responsibility:	Timeline:

Comments/Progress:	

Objective 2:	Increase the number of women who were counseled by their provider about mammograms.
Baseline Data:	No specific data on number of women counseled by provider. For women 50+, 74.6% of survey respondents had a mammogram in the past 2 years. For women 40-50 years old in the Health District, 73.1% of survey respondents have had a mammogram in the past 2 years. Incidence rates for breast cancer (2003-2007) are 118.5 per 100,000 population and deaths due to breast cancer (2005-2009) for NCDHD is 15.5. Compared to the State of Nebraska the incidence rate is 123.2 and a death rate of 21.2
Measurable Outcome:	By 2016, 80% of women 40+ years will self-report that their health care provider counseled them about mammograms.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not provide a service at this time.	$0	Provide education to clinics/ health care providers regarding the importance of providing counseling to	TBD	NCDHD

		patients about the importance of receiving mammograms.		
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 3:	Increase the number of women who receive mammograms according to recommendations/guidelines.			
Baseline Data:	Incidence rates for breast cancer (2003-2007) are 118.5 per 100,000 population and deaths due to breast cancer (2005-2009) for NCDHD is 15.5. Compared to the State of Nebraska the incidence rate is 123.2 and a death rate of 21.2. For women 50+, 74.6% of survey respondents had a mammogram in the past 2 years. For women 40- 50 years old in the Health District, 73.1% of survey respondents have had a mammogram in the past 2 years.			
Measurable Outcome:	By 2016, increase to 82% the number of women who receive mammograms according to recommendations/guidelines.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not provide a service at this time.	$0	Provide education to NCDHD residents about recommendation/guidelines for receiving mammograms via media, health fairs and other venues.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 10:	Increase the percentage of women in the NCDHD area who visit their health care provider for preventive care.

Objective 1:	Increase the number of women aged 21-65 who are screened for cervical cancer according to current guidelines.
Baseline Data:	Incidence rates for cervical cancer (2003-2007) are 2.4 per 100,000 population and deaths due to cervical cancer (2005-2009) for NCDHD is 3.0. Compared to the State of Nebraska the incidence rate is 7.2 and a death rate of 1.6.
Measurable Outcome:	By 2016, 93% of women aged 21-65 years will be screened for cervical cancer according to the current guidelines.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not provide a service at this time.	$0	Provide education to NCDHD residents, health care clinics, and health care providers about the guidelines for cervical cancer screening in women 21-65 years of age via media, health fairs and other venues.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Increase the proportion of women who were counseled by their providers about Pap tests.
Baseline Data:	No specific data for number of women counseled by provider about test. Incidence rates for cervical cancer (2003-2007) are 2.4 per 100,000 population and deaths due to cervical cancer (2005-2009) for NCDHD is 3.0. Compared to the State of Nebraska the incidence rate is 7.2 and a death rate of 1.6.
Measurable Outcome:	By 2016, 80% of women will self-report that their health care provider counseled them regarding Pap tests and cervical cancer.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not currently offer a service.	$0	NCDHD staff members assigned to focus area will work with other group members to determine action items for achieving this objective.	TBD	NCDHD/ Partners
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 11:	Increase education about skin cancer and sun safety to all residents in the NCDHD area.

Objective 1:	Increase the proportion of children, adolescents, and adults who receive education on sun safety and skin cancer prevention to promote personal health and wellness.
Baseline Data:	9.3% of adolescents in grades 9 through 12 followed protective measures that may reduce the risk of skin cancer in 2009, 72.8% of adults aged 18 years and older followed protective measures that may reduce the risk of skin cancer in 2008 (age adjusted to the year 2000 standard population). 72.4% of elementary, middle and senior high schools provided school health education in sun safety or skin cancer prevention to promote personal health and wellness in 2006.
Measurable Outcome:	By 2016, there will be a 10% overall increase in the number of children, adolescents and adults who self-report that they received education on sun safety and skin cancer prevention to promote personal health and wellness.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD has had grants to support community based education and provide sun screen as well as mini grants to increase "shade spots" at local pools. NCDHD also provides public service announcements.	$3,000.	NCDHD will continue to search for funding opportunities to promote sun safety through community education and the availability of small grants to assist community pools in establishing more "shade spots" as infrastructure.	$0	NCDHD

Action Item:	Resources:	Responsibility:	Timeline:

Comments/Progress:	

FOCUS AREA:	Behavioral Health: Mental Health & Substance Abuse

WORK GROUP TEAM MEMBERS

NAME:	ORGANIZATION:
Carriker, Burton	Faith Regional Health Services
Genovese, Jacque	Faith Regional Health Services
Hungerford, Veta	North Central District Health Department
Kellner, Shannon	Heartland Counseling
Miller, Jeanie	NorthStar Services
Miller, Shannon	Avera St. Anthony's Hospital
Mitchell, Terri	West Holt Memorial Hospital

Morse, Ronald P	Avera Medical Group
Ohri, Camille	West Holt Memorial Hospital
Otte, Matt	O'Neill Police Department
Parks, Ryan	North Central District Health Department
Twibell, Sara	North Central District Health Department

GOAL 1:	Increase access to therapeutic mental health services

Objective 1:	Assist providers to become Medicaid/ Medicare providers.			
Baseline Data:	Data not available.			
Measurable Outcome:	By 2016, the number of Medicaid/Medicare mental health providers will increase by 5%.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not provide a service at this time.	$0	NCDHD will make available to health care providers the most current list of underserved population in our district as well as provider shortage areas.	$1,500 for personnel expenses.	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Determine what mental health services and resources are available and develop a frequently updated database.			
Baseline Data:	Data not available.			
Measurable Outcome:	By 2016, a database and resource directory of mental health providers will be readily available to the public.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently lists and updates our internal office data base with contact information of all current providers.	$1,500 in personnel time.	NCDHD will continue to keep our data base of providers up to date.	$1,500	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 3:	Research options for implementing a program encouraging providers to relocate here after schooling. (RHOP recruitment?)
Baseline Data:	Data not available.
Measurable Outcome:	By 2016, two new mental health providers will be recruited.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not provide a service at this time. NCDHD Executive Director continues to reside on the board for the Nebraska Rural Health Association; an organization that works to address this issue state wide.	$1,000 for personnel time.	NCDHD Director will continue to reside on the Rural Health Association Board. NCDHD will support appropriate policy development to encourage such beneficial programs.	$2,000	NCDHD

Action Item:	Resources:	Responsibility:	Timeline:

Comments/Progress:	

Objective 4:	Identify and implement a uniform screening tool for primary care settings to detect mental health issues/needs.
Baseline Data:	Data not available.
Measurable Outcome:	By 2016, implementation of screening tool will be utilized by at least 25% of primary care providers.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not provide service at this time.	$0	NCDHD will support appropriate policy development to encourage such beneficial programs.	$0	NCDHD

Action Item:	Resources:	Responsibility:	Timeline:

Comments/Progress:	

Objective 5:	Educate community and public health agencies on resources available.
Baseline Data:	Directory of resources not currently available.
Measurable	By 2016, resource directory will be available in at least 50 sites in NCDHD territory.

Outcome:				
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently lists and updates our internal office data base with contact information of all current providers and tracks available resources.	$0	NCDHD will continue to keep our data base of providers up to date.	$0	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 2:	Increase the proportion of children with mental health problems who receive treatment.

Objective 1:	Determine options for eliminating transportation problems as a barrier to treatment.			
Baseline Data:	Data not available.			
Measurable Outcome:	By 2016, transportation resources will be included in mental health directory. 50% of people will self-report transportation is NOT a barrier to receiving treatment.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not provide services.	$0	NCDHD will work with our public health partners to promote appropriate public health measures through local and state policy development.	$0	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Educate communities about mental health resources available to ensure treatment is provided as soon as possible when concerns arise.
Baseline Data:	Data not available.
Measurable Outcome:	By 2016, a mental health provider directory will be available.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD currently lists and updates our internal office data base with contact information of all current providers and tracks available resources.	$0	NCDHD will work with our public health partners to promote appropriate public health measures through local and state policy development.	$0	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 3:	Reduce the number of youth who have been bullied in the past 12 months.

Objective 1:	Identify effective methods of reducing bullying.
Baseline Data:	14.5% (9.5% males and 20.4% females; NCDHD YRBS Report, p.22)of 9th,10th,11th,and 12th graders reported "ever" been electronically bullied, i.e., e-mail, chat rooms, instant messaging, web sites or texting, compared to the state average of 16%males and 20% females (NE YRBS Report pp. 9-10). Percentage of student reporting differed little from one grade to the other. 27.1% (26% males and 28.2% females) reported "ever been bullied on school property during the past twelve months". NCDHD rate is significantly above that of Nebraska state rate of 23% and U.S. of 20%.
Measurable Outcome:	By 2016, reduce the percentage of kids who have been electronically bullied to 10%. Also, reduce the reported percentage of kids reporting ever have been bullied on school property to 20%.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not provide program intervention or education. NCDHD does provide personnel time to participate on the Bright Horizons board and local coalitions who address this issue.	$6,000	Will continue to support Bright Horizon's and coalition's endeavors and will determine if other participation if programs/ resources become available.	TBD	NCDHD/ Bright Horizons/ Coalitions
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 4:	Reduce the suicide and attempted suicide rate.

Objective 1:	Determine what mental health services and resources are available and develop a database.
Baseline Data:	No data available.
Measurable Outcome:	By 2016, develop a resource directory.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not currently provide a service.	$0	NCDHD will partner with other workgroup members to research available resources. Work group members will assign responsibility for all steps necessary to develop and maintain a resource directory.	TBD	NCDHD/ Partners

Action Item:	Resources:	Responsibility:	Timeline:

Comments/Progress:	

Objective 2:	Identify/create and implement screening tools for primary care settings to detect mental health issues/needs.
Baseline Data:	No data available.
Measurable Outcome:	By 2016, a uniform screening tool will be utilized in at least 25% of primary care settings.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not currently provide a service	$0	Work group members will work together to determine specific action items for achieving this objective.	TBD	NDHD/ Partners

Action Item:	Resources:	Responsibility:	Timeline:

Comments/Progress:	

Objective 3:	Educate community and public health agencies on resources available.			
Baseline Data:	No data available.			
Measurable Outcome:	By 2016, resource directory will be available in at least 50 locations in the NCDHD territory.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently offer a service.	$0	Work group members will work together to determine specific action items for achieving this objective.	TBD	NDHD/ Partners
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 4:	Identify additional areas of the community (schools, parents, workplaces etc.) where suicide prevention education is needed.			
Baseline Data:	No data available.			
Measurable Outcome:	By, 2016 establish method to assess educational need.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently offer a service.	$0	Work group members will work together to determine specific action items for achieving this objective.	TBD	NDHD/ Partners
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 5:	Identify demographic areas of the community (ages, careers, sexual orientation, etc.) that have risk factors that lead to suicide attempts.			
Baseline Data:	No data available.			
Measurable Outcome:	By 2016, demographic areas with risk factors will be identified and resources will be available to the community.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**

NCDHD does not currently provide a service.	$0	Work group members will work together to determine specific action items for achieving this objective.	TBD	NDHD/ Partners
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 6:	Identify uniform tool to assess risk for adolescent suicide in mental health provider locations.
Baseline Data:	No uniform tool utilized.
Measurable Outcome:	By 2016, 35% of mental health providers will use uniform tool identified.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide a service.	$0	Work group members will work together to determine specific action items for achieving this objective.	TBD	NDHD/ Partners
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 5:	Increase domestic and dating violence awareness and prevention.

Objective 1:	Provide education regarding self-advocacy skills for adolescents.
Baseline Data:	No uniform education for adolescents available.
Measurable Outcome:	By 2016, find/develop a self-advocacy curriculum to be implemented in at least five schools.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not provide program intervention or education. NCDHD does provide personnel time to participate on the Bright Horizons board, a domestic violence survivor support organization.	$2,000	Will continue to support staff time for serving on Bright Horizons board and will work to determine if other programs/resources are available to support.	TBD	NCDHD/ Bright Horizons

Action Item:	Resources:	Responsibility:	Timeline:
Comments/Progress:			

Objective 2:	Provide education through schools, extension about recognition of what healthy relationships and personal boundaries are.
Baseline Data:	No data available.
Measurable Outcome:	By 2016, will implement curriculum in at least five schools.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not provide program intervention or education. NCDHD does provide personnel time to participate on the Bright Horizons board, a domestic violence survivor support organization	$2,000	Will continue to support staff time for serving on Bright Horizons board and will work to determine if other programs/resources are available to support.	TBD	NCDHD/ Bright Horizons

Action Item:	Resources:	Responsibility:	Timeline:
Comments/Progress:			

GOAL 6:	Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.

Objective 1:	Assess risk factors leading to binge drinking behavior.
Baseline Data:	16.6% of adults self-report binge drinking in past month.
Measurable Outcome:	By 2016, reduce number of people with risk factors who self-report binge drinking in past month by 5%.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD currently supports employees who manage and coordinate youth substance abuse coalitions throughout the district. Employees also participate in Region 4 substance abuse	$4,000	Will continue on-going staff contributions.	$4,000	NCDHD/ Coalitions/ Region 4

prevention services. NCDHD also provides PSAs.				
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Identify options for impacting adult acceptance/"cultural norm" status of binge drinking.			
Baseline Data:	No data available.			
Measurable Outcome:	By 2016, 20% of population will perceive binge drinking as a risky behavior.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently supports employees who manage and coordinate youth substance abuse coalitions throughout the district. Employees also participate in Region 4 substance abuse prevention services. NCDHD also provides PSAs. Some of the media campaigns are already geared towards parents.	$4,000	Continue to support on-going contributions of staff. Work group members will work to identify action items.	TBD	NCDHD/ Partners
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 7:	Reduce the past-year, non-medical use of prescription drugs.

Objective 1:	Evaluate current practices of prescription drug dispensing.			
Baseline Data:	No current data available.			
Measurable Outcome:	Complete district wide assessment with providers to develop baseline data for prescription drug dispensing.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**

NCDHD partners with local law enforcement to provide prescription drug take-back days 1/yr in 4 locations.	$4,000	Will continue and investigate options for permanent stations in district.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Increase awareness for perceived risk.
Baseline Data:	No data available.
Measurable Outcome:	By 2016, 50% of people surveyed will perceive risk of using prescription drugs recreationally.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD provides media related to prescription drug take-back days. NCDHD employees also coordinate coalitions who work on this objective.	$4,000	Will continue supporting staff hours on coalitions. NCDHD has applied for grants that will address this issue.	TBD	NCDHD/ Partners
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 3:	Investigate the options for having a stationary drug take-back location.
Baseline Data:	No stationary take-back locations.
Measurable Outcome:	By 2016, establish at least 2 stationary take- back locations in the NCDHD district.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD supports coalition which has had 1 time events in four locations/year for drug take back.	$0	Coalition plans on buying medical take-back station.	TBD	NCDHD/ Coalition
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**

Comments/Progress:			

GOAL 8:	Reduce the past-year use of illegal substances.

Objective 1:	Develop a program encouraging employers to conduct drug testing on employees.			
Baseline Data:	No data available.			
Measurable Outcome:	By 2016, enlist support of drug testing via Worksite Wellness Programs in at least 5 work places in county.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide a service.	$0	NCDHD Wellness Program training may include this.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 9:	Reduce tobacco use.

Objective 1:	Increase the recognition for risks of smokeless tobacco.			
Baseline Data:	No current data on perceived risk. 48.4% of men in NCDHD area have ever used smokeless tobacco. 29.8% said currently use smokeless tobacco, this rate is significantly higher than the statewide rate of 12.6%			
Measurable Outcome:	By 2016, baseline data for perceived risk will be established. Current smokeless tobacco usage will decrease to 24%.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide service. NCDHD employees coordinate coalitions who work on this objective.	$0	Continue coalition work and work group members will work to determine action items for adults as well.	TBD	NCDHD/ Partners
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Provide tobacco-free workplace tools to employers.
Baseline Data:	No data available.

Measurable Outcome:	By 2016, 30% of employers in NCDHD will have tobacco-free information available for employees.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
In the past NCDHD contacted all businesses that allowed smoking (i.e. bars, bowling alleys, hotels) to distribute no-smoking materials. Currently NCDHD holds a contract to investigate and enforce matters concerning the Clean Indoor Air Act.	$2,000	Will continue to maintain the contract. NCDHD Wellness Program training may include this.	TBD	NCDHD
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

FOCUS AREA:	**Chronic Disease, Obesity, & Related Health Concerns**

WORK GROUP TEAM MEMBERS

NAME:	ORGANIZATION:
Brown, Tammy	Brown County Hospital
Bunner, Stephanie	North Central District Health Department
Cork, Ron	Avera St. Anthony's Hospital
Emory, Monica	Faith Regional Health Services
Frisch, Lenice	Avera Creighton Hospital
Frost, Mikki	Alegent Creighton Health
Gamel, Rick	Alegent Creighton Health Plainview Hospital
Genovese, Jacque	Faith Regional Health Services
Green, Jack	Antelope Memorial Hospital
Hart, Peggy	North Central District Health Department
Johnson, Geri	Brown County Hospital
Kalkowski, Kelly	Niobrara Valley Hospital
Knox, Stacey A	Rock County Hospital
Mlady, Celine	Osmond General Hospital
Morse, Ronald P	Avera Medical Group
Plate, Carol	UNL Extension – Retired / NCDHD Board of Health member

GOAL 1:	Improve the nutrition and weight status of all citizens in the nine counties defined by NCDHD.

Objective 1:	Increase the proportion of schools that offer nutritious food and beverage options outside of school meals by offering fruits or vegetables whenever other food is offered or sold.
Baseline Data:	6.6% of school districts required schools to make fruits or vegetables available whenever other foods were offered or sold.
Measurable Outcome:	By 2016, 18.6% of school districts will offer fruits or vegetables whenever other foods are offered or sold.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not currently provide program activity or education regarding this.	$0	NCDHD will provide personnel time to schools to assist with policy development and technical assistance.	$1,500/yr	NCDHD Nurse Health Educators

Action Item:	Resources:	Responsibility:	Timeline:

Comments/Progress:	

Objective 2:	Increase the proportion of children and adolescents who do not exceed recommended limits for screen time (electronics).
Baseline Data:	78.9% of children and adolescents aged 6-14 years viewed television, videos, or played video games for no more than 2 hours a day in 2007
Measurable Outcome:	By 2016, 86.8% of children and adolescents aged 6-14 years will view television, videos or play video games for no more than 2 hours a day.

Programs/Resources that are currently Committed to this Priority:	Current Budget:	Programs/Resources that will be Committed to this Priority:	Future Expected Budget:	Responsible Parties:
NCDHD does not currently directly provide programs or education.	$0	NCDHD will assist other work-group members through services of health education.	$1,500/yr	Health Educator/ Nurse Health Educator

Action Item:	Resources:	Responsibility:	Timeline:

Comments/Progress:	

Objective 3:	Reduce the proportion of adults who do not engage in any leisure time physical activity.
Baseline Data:	In the NCDHD survey, 23% of respondents do not exercise at all and 77% of respondents said that they exercise, of those, only 26% reach the levels recommended by the CDC.

Measurable Outcome:	By 2016, increase the number of adults who engage in recommended levels of leisure time physical activity to 35%.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not directly provide direct services or education.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr	NCDHD Health Educator/ Nurse Health Educator
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

GOAL 2:	Improve access to diabetes education and screening to all people in the counties defined by NCDHD.

Objective 1:	Increase prevention behaviors in persons at high risk for diabetes and pre-diabetes.			
Baseline Data:	44.6% of adults aged 18 years and older who were at high risk for diabetes with pre-diabetes reported increasing their levels of physical activity in 2005-08 (age adjusted to the year 2000 standard population), 48.5% of adults aged 18 years and older who were at high risk for diabetes with pre-diabetes reported reducing the amount of fat or calories in their diet in 2005-08 (age adjusted to the year 2000 standard population)			
Measurable Outcome:	By 2016, there will be an increase in the percentage of adults 18 years and older who report increasing their physical activity level (54%) and have reduced the amount of fat or calories in their diets (56.0%) who were at high risk for diabetes with pre-diabetes.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently have programs committed. Resources consist of personnel time through education.	$1,000	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$2,500/yr.	NCDHD health educator/ Nurse educator
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Increase the proportion of persons with diabetes whose condition has been diagnosed.
Baseline Data:	In the NCDHD survey, 70% of respondents had been tested for diabetes within the past two years and 19% have never been tested. 72.8% of adults aged 20 years and older

	with diabetes had been diagnosed, as reported in 2005-2008 (age-adjusted to the year 2000 standard population)
Measurable Outcome:	By 2016, increase to 80% of the NCDHD population will have been tested for diabetes.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not provide services or consistent education for blood sugar testing.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr.	NCDHD health educator/ Nurse health educator

Action Item:	**Resources:**	**Responsibility:**	**Timeline:**

Comments/Progress:	

Objective 3:	Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education.
Baseline Data:	56.8% of adults aged 18 years and older with diagnosed diabetes reported they ever received formal diabetes education in 2008 (age-adjusted to the year 2000 standard population)
Measurable Outcome:	By 2016, 62.5% of adults aged 18 and older who are diagnosed with diabetes will self-report that they have received formal diabetes education.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not provide services or consistent education for blood sugar testing.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,000/yr.	NCDHD health educators

Action Item:	**Resources:**	**Responsibility:**	**Timeline:**

Comments/Progress:	

GOAL 3:	Decrease the overweight and obese citizens in the counties defined by NCDHD.

Objective 1:	Increase the proportion of primary care physicians who regularly measure the body mass index (BMI) in patients.
Baseline Data:	48.7% of primary care physicians regularly assessed body mass index (BMI) in their adult patients in 2008.In Nebraska the prevalence of obesity has nearly doubled between

	1995 (16.3%) and 2011 (28.4%, BRFSS). In the NCDHD survey, the average BMI was 28.44. The 2008 BRFSS study for NCDHD reported 26% as obese, and 40% overweight, in the 2012 NCDHD survey 35% of respondents are obese.			
Measurable Outcome:	By 2016, 53.6% of primary care providers will report that they provide patients with their body mass index at visits.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not provide services or consistent education regarding BMI.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,000/yr.	NCDHD health educators
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Increase the proportion of physician office visits that include counseling or education related to nutrition or weight.			
Baseline Data:	12.2% of physician office visits of all child or adult patients included counseling about nutrition or diet in 2007 (age adjusted to the year 2000 standard population).In Nebraska the prevalence of obesity has nearly doubled between 1995 (16.3%) and 2011 (28.4%, BRFSS). In the NCDHD survey, the average BMI was 28.44. The 2008 BRFSS study for NCDHD reported 26% as obese, and 40% overweight, in the 2012 NCDHD survey 35% of respondents are obese. 48.7% of primary care physicians regularly assessed body mass index (BMI) in their adult patients in 2008.			
Measurable Outcome:	By 2016, 17.2% of physician offices will report that they provide counseling or education on nutrition and weight during office visits.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide services or education regarding nutrition and weight management in doctor's offices.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr/	NCDHD health educators
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 3:	Increase the proportion of community members who are educated in nutrition and weight issues.
Baseline Data:	No specific data on numbers of people who have received education. In Nebraska the prevalence of obesity has nearly doubled between 1995 (16.3%) and 2011 (28.4%, BRFSS). In the NCDHD survey, the average BMI was 28.44. The 2008 BRFSS study for NCDHD reported 26% as obese, and 40% overweight, in the 2012 NCDHD survey 35% of respondents are obese. 48.7% of primary care physicians regularly assessed body mass index (BMI) in their adult patients in 2008. 12.2% of physician office visits of all child or adult patients included counseling about nutrition or diet in 2007 (age adjusted to the year 2000 standard population).
Measurable Outcome:	By 2016, 30% of community members will self-report that they received education in nutrition and weight issues.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide (direct) services or education regarding this.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr.	NCDHD health educators

Action Item:	**Resources:**	**Responsibility:**	**Timeline:**

Comments/Progress:	

GOAL 4:	Increase overall cardiovascular health of citizens in counties defined by NCDHD.

Objective 1:	Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether or not it was normal or high**.**
Baseline Data:	In the NCDHD study, 93.2% reported having a recent blood pressure test and 34% of respondents reported that they were diagnosed with high blood pressure.
Measurable Outcome:	By 2016, 95% of adults in the NCDHD district will have had their blood pressure measured within the preceding 2 years and can state whether or not it was normal or high.

Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide (direct) services or education regarding this.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr.	NCDHD health educators

Action Item:	**Resources:**	**Responsibility:**	**Timeline:**

Comments/Progress:			

Objective 2:	Increase the proportion of adults who have had their blood cholesterol checked within the preceding 2-5 years.			
Baseline Data:	In the NCDHD 2012 survey, 80% reported that they had their cholesterol checked within the past 2 years. 30.8% reported that they had been told by a health care professional that they have high cholesterol. The prevalence of high cholesterol in the NCDHD district was almost three times the 2020 target (32.7%:13.5%).			
Measurable Outcome:	By 2016, 85% of adults will report that they have had their blood cholesterol checked within the preceding 2 – 5 years.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide (direct) services or education regarding this.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr.	NCDHD health educators
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 3:	Increase the proportion of adults ages 20 years and older who are aware of and respond to early warning signs and symptoms of a heart attack.			
Baseline Data:	39.6% of adults aged 20 years and older were aware of the early warning signs of a heart attack in 2008 (age adjusted to the year 2000 standard population).			
Measurable Outcome:	By 2016, 45% of adults ages 20 years and older will be aware of and respond to early warning signs and symptoms of a heart attack.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide (direct) services or education regarding this.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr.	NCDHD health educator
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 4:	Increase the proportion of adults ages 20 years and older who are aware of and respond to early warning symptoms and signs of a stroke.			
Baseline Data:	53.9% of adults aged 20 years and older were aware of the early warning signs and symptoms of a stroke (age adjusted to the year 2000 standard population).			
Measurable Outcome:	In 2016, 59.3% of adults ages 20 years and older who are aware of and respond to the early warning symptoms and signs of a stroke.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide (direct) services or education regarding this. NCDHD has provided public health education.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr.	NCDHD health educator
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 5:	Increase the proportion of children who have had their blood pressure measured within the preceding 2 years.			
Baseline Data:	No specific data on how many children have had blood pressure measured. 3.5% of children and adolescents aged 8-17 years had high blood pressure/hypertension in 2005-2008			
Measurable Outcome:	BY 2016, 50% of parents will report that their children aged 8-17 years will have had their blood pressure measured within the preceding 2 years.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not currently provide (direct) services or education regarding this.	$0	NCDHD will dedicate personnel time to the work-group, providing assistance with policy development and/or technical assistance.	$1,500/yr.	NCDHD health educators
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

FOCUS AREA:	Environment & Safety

WORK GROUP TEAM MEMBERS	
NAME:	**ORGANIZATION:**
Fritz, Ann	North Central District Health Department
Genovese, Jacque	Faith Regional Health Services
Hungerford, Veta	North Central District Health Department
Jones, Pat	UNL Extension
Knievel, Lon	Tilden Community Hospital
Mitchell, Terri	West Holt Memorial Hospital
Morse, Ronald P	Avera Medical Group
Olson, Linda	Bright Horizons

GOAL 1:	Reduce the number of reported families living in unsafe environments.

Objective 1:	Identify and collect current, relevant data to establish a reference baseline.			
Baseline Data:	No current data available.			
Measurable Outcome:	By 2016, relevant baseline data will be made available to households in NCDHD.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
Environmental information is available regarding radon exposure and household mold.	$4,000/yr.	Continue with offering testing for radon and mitigation resources for mold growth.	$4,000/yr.	NCDHD Disease & Epi.
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Increase the number of communities that have and enforce safe- housing standards.			
Baseline Data:	No specific data available. Communities have ordinances and not safe housing standards.			
Measurable Outcome:	By 2016, 25% of communities in NCDHD territory will enact enforcement of safe-housing standards.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently conducts	$2,500	Continue site visits and work	TBD	NCDHD

environmental site visits when a complaint is called in and then information is passed to city/village.		group members will determine action items.		
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 3:	Increase the number of households testing for specified hazardous living conditions: radon, unsafe water, toxic chemicals, lead and mold.			
Baseline Data:	19.4% of households tested for radon. 58% of households have never had their water supply tested (private well, city/village water, or rural water system). NCDHD has a significantly higher percentage of children with elevated blood levels when compared to the state. No specific data exists for mold and other toxic chemicals.			
Measurable Outcome:	By 2016, 25% of households in NCDHD will have tested for at least two hazardous conditions.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD supports radon testing through the availability of kits	$3,000/yr.	Radon testing will continue.	$3,000/yr.	NCDHD Disease & Epi.
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 4:	Increase education and events to improve family structure.			
Baseline Data:	No current data.			
Measurable Outcome:	By 2016, there will be at least 3 events/education sessions per county that promote and educate about healthy family structure.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD provides youth summits and information at health fairs.	$12,000/yr.	NCDHD will continue to provide youth summits and health family information at community fairs.	$12,000/yr.	NCDHD Health Education.
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**

Comments/Progress:	

GOAL 2:	Reduce fatal and non-fatal incidents and injuries.

Objective 1:	Identify and collect current, relevant data to establish reference baseline.			
Baseline Data:	NCDHD is significantly higher than the state in: occupational injuries/illnesses/farm injuries; unintentional injury deaths, motor vehicle deaths, and work-related accidental death rates.			
Measurable Outcome:	By 2016, collect and analyze data pertaining to above mentioned accidents/fatalities formulate plan for addressing areas of risk.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD collects data and has available for dissemination to the community.	$5,000/yr.	NCDHD will compile data into a report and make available to work-group and community to help address needs.	$5,000/yr.	NCDHD Disease & Epi and Resource Management
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

Objective 2:	Reduce non-fatal physical assault injuries.			
Baseline Data:	According to the framework for the Nebraska 2020 Healthy People Objectives, from 1999-2003 the average number of Nebraskan's admitted or treated in hospitals for assault was 3,544. Healthy People 2020 reports 514.1 emergency department nationwide visits for nonfatal physical assault injuries per 100,000 population occurred in 2008 (age adjusted to the year 2000 standard population).			
Measurable Outcome:	By 2016, there will be no more than 3,190 people admitted/ treated in hospitals due to physical assault injuries.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD does not provide program intervention or education. NCDHD does provide personnel time to participate on the Board of one domestic-assault prevention organization and BRAVO Youth Support	$1,500/yr.	NCDHD will continue to provide personnel time to such Board and BRAVO Youth Group Coordination.	$2,500/yr.	NCDHD PH Educator

Group.				
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

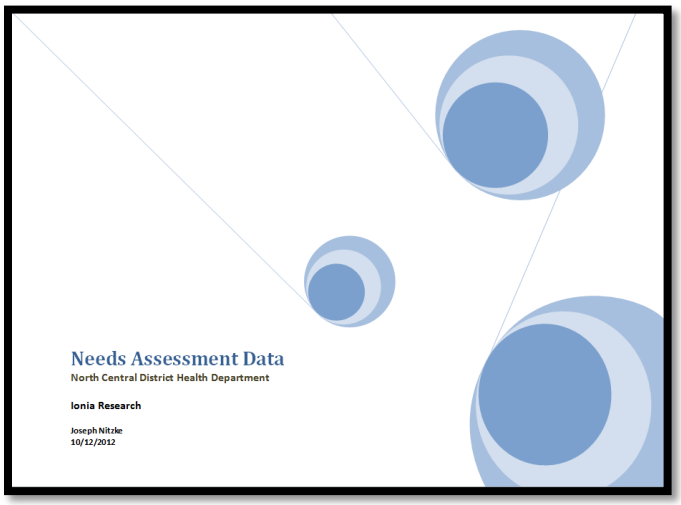
Objective 3:	Reduce the number of people injured as a result of distracted driving.			
Baseline Data:	According to DHHS from 2005 to 2009, distracted driving resulted in 173 deaths, 14,000 injuries. The Nebraska Office of Highway Safety states, in 2011, there were 3515 drivers involved in distracted driving crashes. From the framework for Nebraska's 2020 Healthy People Objectives, motor vehicle crashes were the leading cause of injury death and the fourth leading cause of injury hospital discharge in Nebraska with an average of 238 deaths and 11,832 discharges from 2000 to 2003.			
Measurable Outcome:	By 2016, there will be a 10% decrease in the number of people involved in distracted driving injuries yearly.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD supplies staff hours for coalition management/ coordination who have provided distracted driving activities in schools.	$4,000	Will continue supporting coalitions endeavors. Work group members will determine action items to achieve this objective.	TBD	NCDHD/ Coalitions
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

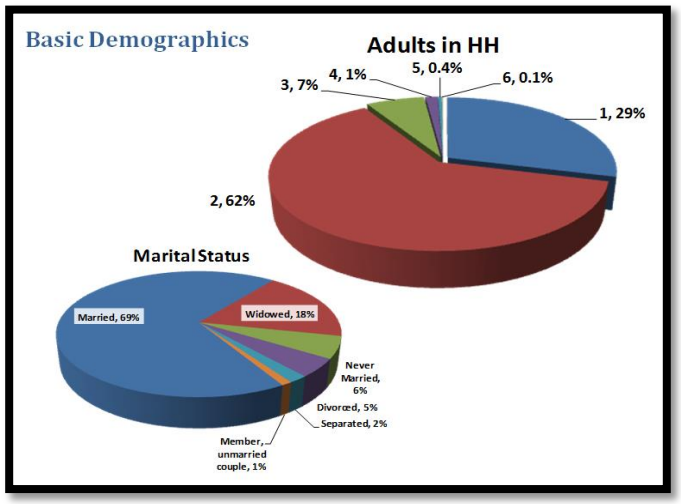
Objective 4:	Reduce the number of injuries of people over 65 years old, in their home environment.			
Baseline Data:	According to the DHHS Nebraska Injury Report from 2004 to 2008, unintentional falls were the leading cause of hospitalizations and emergency department visits due to injury among Nebraskans, and the third leading cause of injury death. From 1999 to 2003, the death rate due to falls in NCDHD area was 4.7/100,000 population. Falls were the leading cause of injury hospital discharges with an age adjusted rate of 1,801/100,000 from 1999-2003 in the NCDHD area.			
Measurable Outcome:	By 2016, reduce the mortality rate due to falls to 3.7/100,000 and fall related morbidity hospital discharges 1,700/100,000 respectively.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**

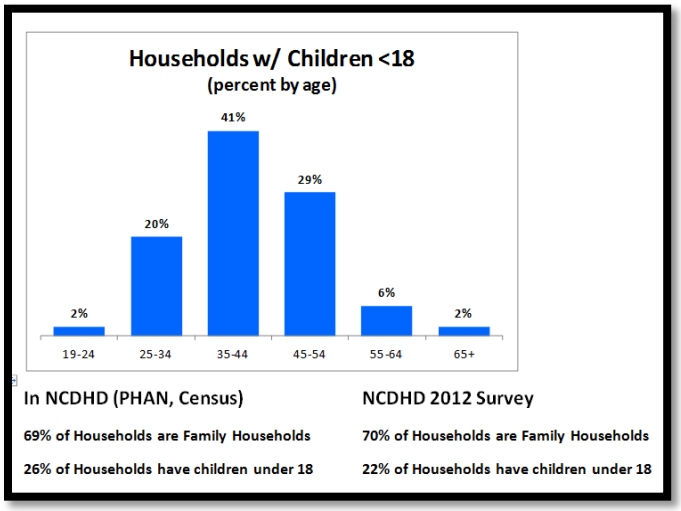
NCDHD currently does not direct program activity or education.	$0.	NCDHD will support the work-group by providing personnel time for data management.	$2,000/yr.	Resource Management
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

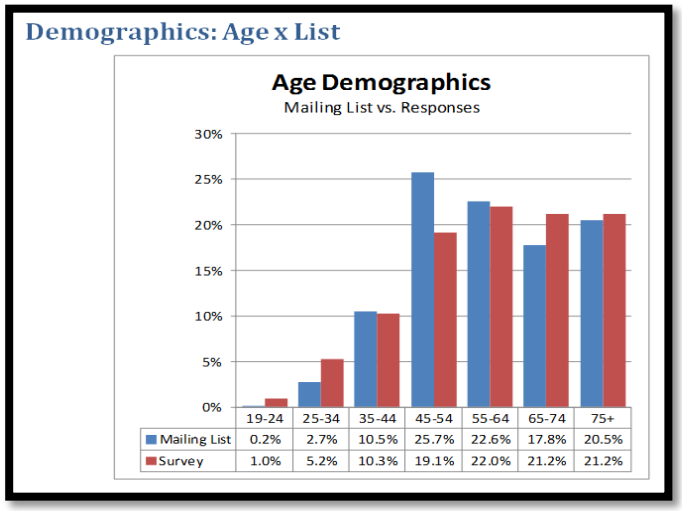
Objective 5:	Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity as reported by employers.			
Baseline Data:	4.2 injuries per 100 full-time equivalent workers in private sector industries resulted in medical treatment, lost time from work, or restricted work activity, as reported by employers in 2008.			
Measurable Outcome:	By 2016, 3.6 injuries per 100 full time workers in all sectors of industry will require medical treatment, lost time from work, or restricted work activity as reported by employers.			
Programs/Resources that are currently Committed to this Priority:	**Current Budget:**	**Programs/Resources that will be Committed to this Priority:**	**Future Expected Budget:**	**Responsible Parties:**
NCDHD currently offers a worksite wellness program offering technical assistance as a resource.	$3,000/yr.	NCDHD will offer resources in the worksite wellness program through technical assistance for reducing worksite injuries.	$5,000/yr.	NCDHD Health Educator & PH Nurse
Action Item:		**Resources:**	**Responsibility:**	**Timeline:**
Comments/Progress:				

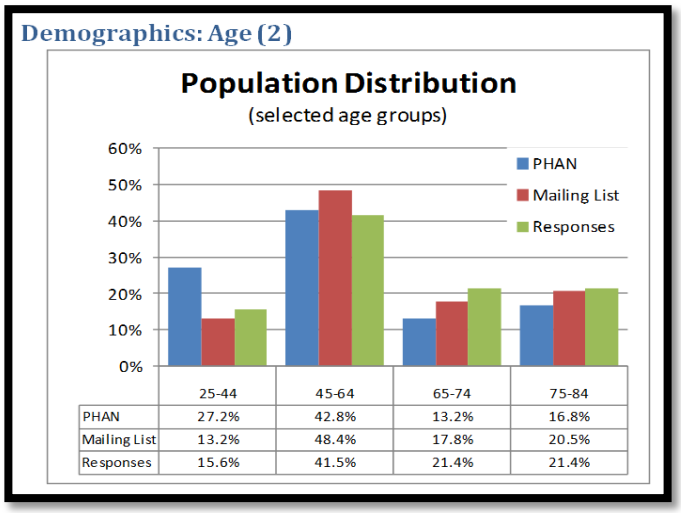
10.A NEEDS ASSESSMENT DATA

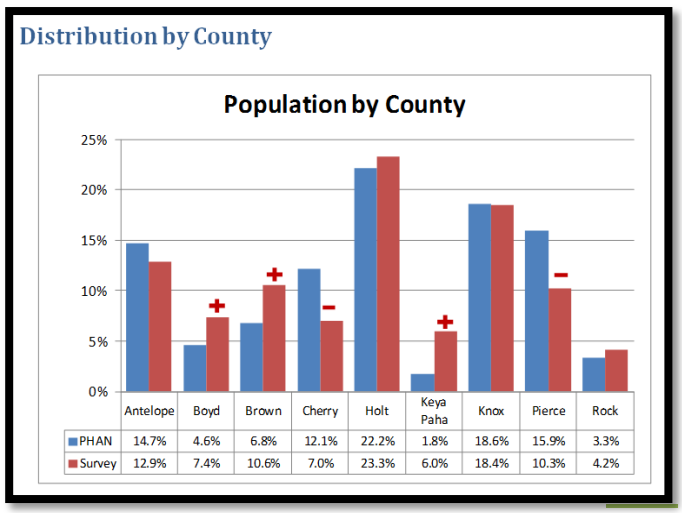


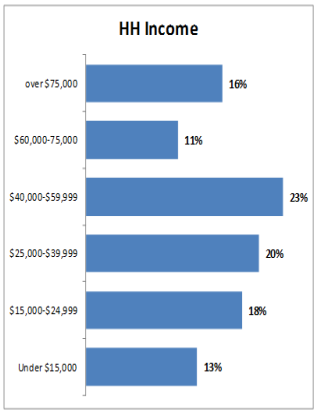






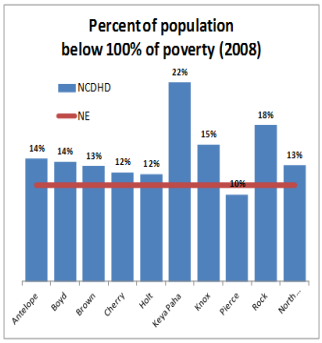






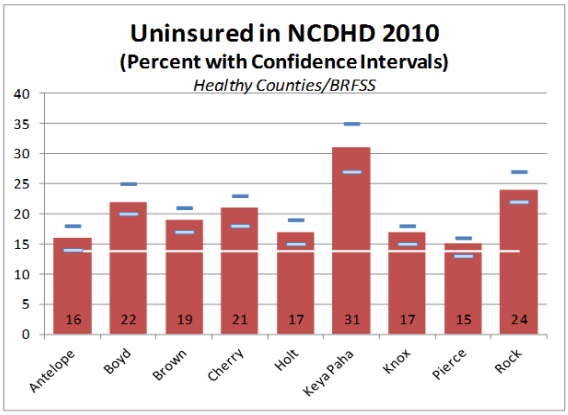
Income

Of those respondents reporting less than $15,000 household income, 68% are 65 and older ($15-24,000, 62% are 65+; 73% of those 65+ report income of less than $40,000).



Health Care Access

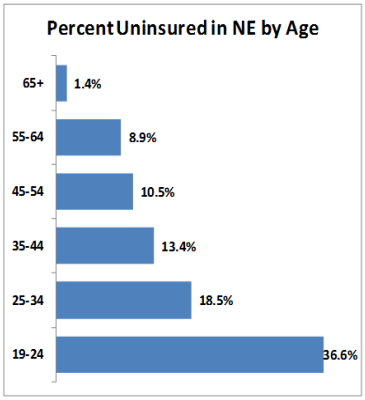
One in five residents do not have health insurance.



- 19.5% (NCDHD BRFSS) of respondents aged 18 to 64 years reported having no health insurance at the time of the survey.
- 17.6% (RWJ Health Rankings) of those under 65 years were uninsured;
- 20.9% of those 18-64 were uninsured (RWJ).

In Persons

- *5,177 of those age 18-64 (N=24,713) are uninsured, and*
- *6,133 of all under 65 (N = 34,880) are uninsured.*



In Healthy People 2020 insurance is a metric for Access to Health Care (insurance and the proportion having a usual primary care provider).

The 2020 Goal is to increase the proportion of persons with health/medical insurance to 100%, from a baseline of 83.2% in 2008.

Barriers and Delays in Obtaining Health Care

Barriers, 2012

- 43% reported barriers to obtaining health care (57% reported no 'barriers' to obtaining health care.)
  - One in eight (13%) cited *high co-pays.*
  - 35% of those uninsured couldn't pay for prescription medicine in the past year.
  - Of those uninsured, 61% did not get a flu shot.
  - Of all respondents, with and without insurance, 8.2% of all respondents could not pay for prescription medicines. (HP2020 Goal: 2.8%)
- In the 12 months before the 2008 BRFSS survey, nearly 10% who needed to see a doctor did not because of the potential cost of care.

Other Surveys

- 19.6% always delay health care.
- 74.5% Sometimes/Always delay health care.

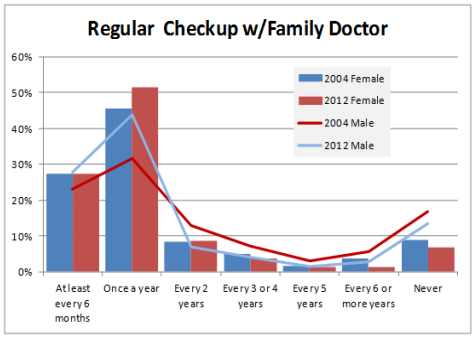
Community Action Agency Survey 2010

Personal Physician

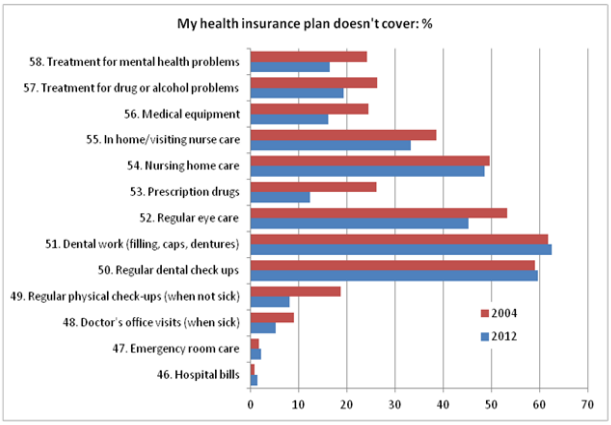
Most (94%) of the survey respondents have a primary care doctor, an increase from the 2004 survey (89%). Other surveys:

- Community Action Survey: 85% have a regular family doctor.
- BRFSS, 2008 reports 81% have a personal doctor or health care provider.

A Healthy 2020 goal for *Access* is to increase the proportion of persons with a usual primary care provider to 83.9% from a baseline of 76.3 percent. *Based on the 2008 BRFSS data (81%), the district is most likely short of that goal.*



Insurance Does Not Cover

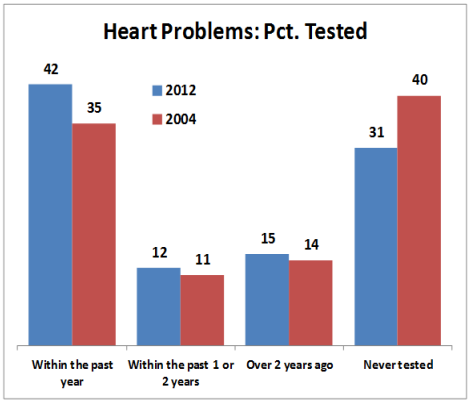


Cardiovascular (Heart Problems)

Family History: 60%, slight increase since 2004 (56%).

The proportion tested within the past two years has increased from 47% in 2004 to 54% in 2012.

Recent Diagnosis: 12% in 2012 have been told by a health professional they have heart problems. [1]



[1] Though the (112.6/100,000)due coronary disease is not significantly higher than the state rate of 91.7, that rate is higher than the HP2020 target of 100.8 deaths per 100,000 population.

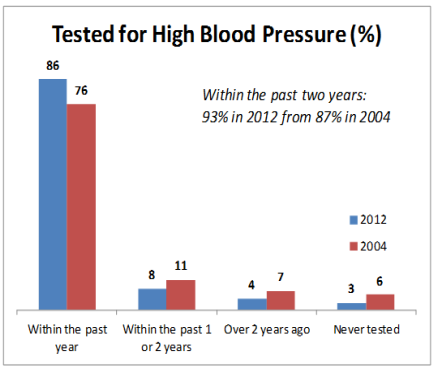
High Blood Pressure

Percent diagnosed with high blood pressure

- 30% in 2004 Survey
- 26% in 2009 PHAN/BRFSS for NCDHD
- 34% in 2012 Survey
- 29% in Nebraska, 2011

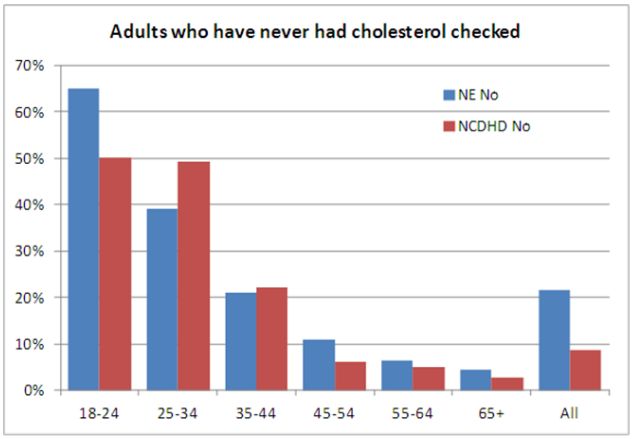
Of those 62% with a family history, 80% have been told by a HP they have HBP.

The HP2020 target for high blood pressure was revised for 2020 to 26.9%.



The rate of deaths due to stroke in the HD was significantly higher than that of Nebraska (HD, 47.6; NE, 42.9). The HP 2020 target is 33.8 deaths per 100,000 population.

Cholesterol



Survey Response (cont.)

2004: 64% were checked within the past two years.

2012: 80% of respondents had their cholesterol checked within the past two years.

(The proportion of those never tested decreases with Age; increases with Education.)

High Cholesterol BRFSS

Advised by HP. Of those tested, 30.8% of survey respondents were advised by a health professional that they have high cholesterol (2012 Survey).

2008 NCDHD BFRSS: 25.5%

2008Nebraska: 32%

2010 Nebraska: 37%

NCDHD is very close to the HP2020 Goal for having cholesterol checked (To Increase the proportion of adults aged 18 years and older who have had their blood cholesterol checked within the preceding 5 years to 82.1% from 74.6% (2008 benchmark).

Weight

Nebraska: In 2002, 23% of Nebraskans were obese; in 2011 that proportion has increased to 28%.

In the 2004 Health District survey, the average BMI for HD respondents was 27.88; in 2012 the average increased to 28.44.

2012 Survey

Normal Weight: about one third (30.5%), a slight increase from 2004 (29.8%);

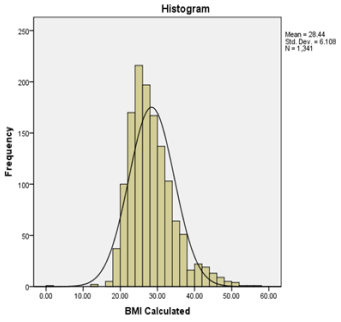
Overweight: three of ten (34.9%), compared to 42.4% in 2004; and

Obese: one third (33.7%) obese, compared to 27.8% in 2004.

In Nebraska, the prevalence of obesity has nearly doubled between 1995 (16.3%) and 2011 (28.4%).

HP 2020 Healthy Weight: 33.9%

HP 2020 Obesity: 30.6%



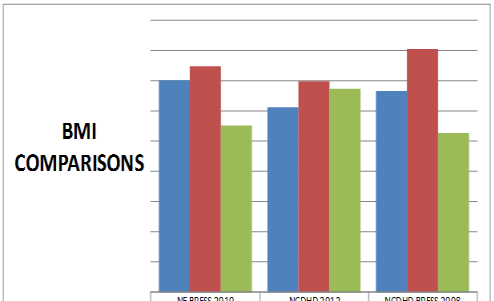
Weight and Family History

About half (48.4%) of the respondents to the NCDHD survey reported a family history of being overweight. In 2004, 44%.

Of those with a family history, 85.9% are overweight/obese (32.8% overweight; 53.1% obese).

Of those who responded *No*, 46.5% are normal weight, 37.3% are overweight, and 15.2% are obese.

In practical terms, between 10-12,000 of the adults served by NCDHD would be categorized as obese.



	NE BRFSS 2010	NCDHD 2012	NCDHD BRFSS 2008
NORMAL	35.1	30.5	33.3
OVERWEIGHT (bmi 25.0 - 29.9)	37.4	34.9	40.3
OBESE (bmi 30.0 - 99.8)	27.5	33.7	26.4

Current Weight Loss Attempts (Over the past two years)

One in five (19%) of respondents have been told by a health professional that they have obesity/weight problems. Of these, one in six (16%) is overweight, and four of five (82%) are obese.

Of all respondents, two-thirds (65%) are trying to lose weight, and 44% limit the fat in their diets *Often-Always*. In the 2004 study, 49% were trying to lose weight, and 33% limited the fat in their diets *Often-Always*.

Overweight: 70% of those overweight are trying to lose weight, 29% are not; 46% limit the fat in their diet *Often-Always*.

Obese: 89% are trying to lose weight, and 39% limit the fat in their diet *Often-Always*.

HP2020

HP 2020 Healthy Weight: 33.9%

HP 2020 Obesity: 30.6%

Youth and Weight (YRBS)

- 72% are at a Healthy Weight for their age.
- One in four (26%) are either overweight or at risk of being overweight.

Youth report that to control weight they have gone without eating for 24 hours or more (8.8%); 3% have taken pills, diet powders, or liquids to lose weight; and 2.2% reported that they vomited or took laxatives to lose weight or to keep from gaining weight.

Diabetes

Prevalence. Nearly half (49.5%; 2004 = 46.8%) reported a family history of the disease. One in ten (11%) have been told by a health professional that they have diabetes.

Two thirds (70%) of the respondents were tested for diabetes within the past two years, while one in five (19%) have never been tested for diabetes.

The prevalence of diabetes in the HD is about the same as that for Nebraska. The rate for diabetes related deaths in the HD (78.6 per 100,000; NE is 81.2) is significantly lower than that of the state; however, both are about 20% above the 2020 HP goal of 65.8/100,000.

Dental care. An HP2020 Goal is to increase the proportion of persons with diagnosed diabetes who have at least an annual dental examination to 61.2%. In the 2012 survey, 63% of diabetic adults report having at least an annual dental exam.

Eye Exam. The HP202 Goal is to increase the proportion of adults with diabetes who have an annual dilated eye examination to 58.7%; in the survey 70% of diabetic adults reported having an eye exam annually.

Other rates: hospitalization for diabetes in the HD is significantly lower than that of the state; the proportion of diabetics who have their blood pressure checked at least every two years is 95%.

Exercise

75% report that they exercise in HD and in NE.

In the NCDHD survey the percent of adults *who have not exercised* decreased since 2004 (2004, 32.8% of respondents responded 'no' to the exercise question; 25% in 2012).

Conversely, 75% of respondents answered 'yes' to exercise in 2012, an increase from 67.2%.

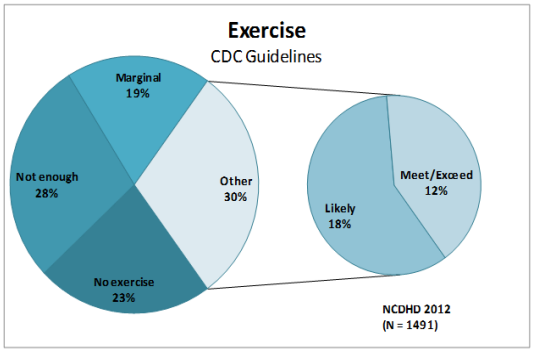
For NCDHD respondents, exercise decreases with age, from 92% for the youngest level to 73% for the oldest demographic. Exercise increases with income.

Two-fifths (39%) exercise less than two times per week, which compares favorably to the 2004 response (43%). In 2012, one in four (24%) exercise five or more times per week.

The proportion of respondents whose exercise periods are more than 30 minutes has increased from 36% in 2004 to 39% in 2012.

103. Each week I exercise			104. When I exercise, I exercise for		
	2012 %	2004 %		2012 %	2004 %
Less than 1 time	15.4	9.2	Less than 20 minutes	31.9	31.8
1 or 2 times	24.0	33.8	20-29 minutes	28.8	32.5
3 or 4 times	36.9	31.8	30 minutes or more	39.4	35.7
5 or more times	23.7	25.3	Total	100	100
Total	100	100	System		

Exercise



- One half (51%) are below the levels recommended by the CDC.
- One in eight (12%) meet or exceed the guidelines (2 hours 30 minutes per week, the threshold for moderate exercise);
- One in five (18%) are likely to meet the guidelines, depending on whether their exercise is moderate or vigorous (if it is vigorous, yes; if moderate, no).

Exercise (cont.)

103. Each week I exercise * 104. When I exercise, I exercise for Cross tabulation

103. Each week I exercise		104. When I exercise, I exercise for			Total
		Column 1 Less than 20 minutes	Column 2 20-29 minutes	Column 3 30 minutes or more	
Cell1	Less than 1 time	9.8%	1.1%	0.7%	11.7%
Cell 2	1 or 2 times	10.6%	8.8%	5.6%	25.0%
Cell 3	3 or 4 times	8.0%	13.3%	17.3%	38.6%
Cell 4	5 or more times	3.1%	5.5%	16.1%	24.7%
	Total (N)	363	330	456	1149

Environment

Pesticides: Inside the Home

One in four respondents (27.8%) used pesticides inside the home. Of those, chemicals were applied on average 5.59 days per year. The number was wide ranging, with a median of 2 days and a range of 1 through 190.

Outside the Home

Half of the respondents (53.8%) reported applying chemicals in the yard. The average was about the same as indoors (4.52 days) as was the median (2days). The range, however, was 1-365.

Radon

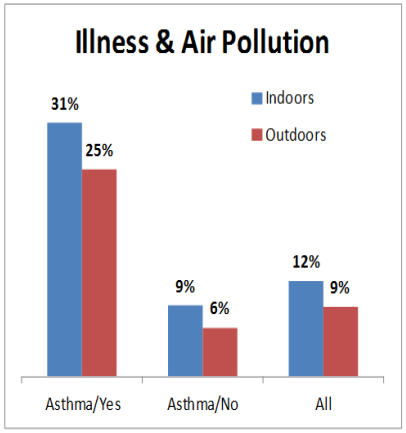
A positive finding is that the percent who have their home tested for radon doubled between 2004 (9.6%) and 2012 (19.4%).

Asthma

About one in eight (13.5%) have asthma.

- In the 2008 BRFSS report, the proportion of adults in the NCDHD *ever* diagnosed with asthma was 9.6%; 6.5% currently have this disease, according to the report.
- For Nebraska (BRFSS, 2010) a similar proportion were diagnosed with asthma (12.2%: CI 11.1-13.4).

The 2012 Survey asked if respondents had an illness or symptom caused by something in the air (indoors and outdoors).

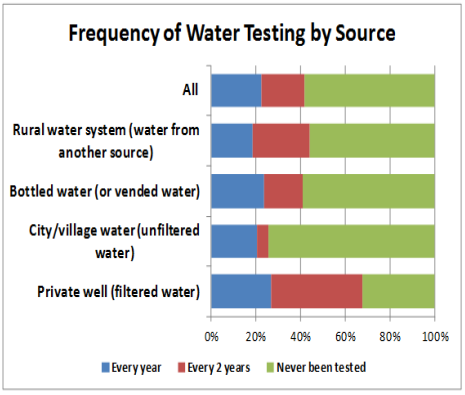


Water

About one third (29%) of households rely upon a private well for water, while half (52%) use *city/village water*. Overall, more than half (58%) report never having had their water tested.

Of those who rely on a private well, one-third (33%) have never had their water tested.

Of those with city/village water, 75% have never had their water tested (it is unclear if the city/village conducts testing on its own).



Over half of those who use a rural water system (56%) have never had their water tested.

Tobacco

Current Prevalence. In the 2008 BRFSS report for the district, 17.8 % said they currently smoke cigarettes, either daily or on some days of the month. Among current smokers, 51.1% reported trying to quit smoking at least once in the past 12 months. Nearly one-half of men in the North Central District (48.4%) said they had ever used smokeless tobacco, while 29.8. % stated they currently use these tobacco products. This current rate of smokeless tobacco use is significantly higher than the statewide rate of 12.6%.

RWJ County Health Rankings estimate the prevalence at just over 18%; *of nearly 35,000 adults, 6,300 are current smokers.*

Current Smokers: 2012 Survey

For these respondents, only 7.2 percent are current smokers.

Of current smokers, two-thirds (67%) smoke some days or every day. Overall, the prevalence of smoking reported in the 2012 survey is lower than that reported in 2004. For example, In 2012, 13% of current smokers smoked more than a pack per day, which is down from the 25% reported in 2004.

In addition, 10.6% said they have ever used or tried any smokeless tobacco product; currently, only 2.4% use smokeless tobacco (in the 2004 survey, 7.7% were current users). In 2004 4.5% reported using other tobacco products (cigars, pipes, etc.), but in 2012 other tobacco usage decreased to 1.9%.

Youth Tobacco Use (2010 YRBS)

One-third (35%) of youth have tried smoking, with males more likely to have smoked (39%) than females (30%).

About one in six (14%) currently smoke.

Of those, 8% considered themselves regular smokers (at least one per day for 30 days).

Any Tobacco

A calculated variable for tobacco users (all tobacco products) from the NCDHD results shows that 8.6% of all respondents use some type of tobacco product. In 2004, 21.7% of the respondents used one or more forms of tobacco.

The pattern of usage by demographics is different than that for smoking. Unlike smoking, increasing age actually shows an increase in the proportion who use tobacco. The same is true of income and education. What this suggests is that other tobacco use morphs with age, so that those who once smoked may now be using smokeless tobacco, cigars, or pipes.

Tobacco: Goals and Comment

For adults, the HP2020goal is to reduce cigarette smoking to 12% from 20.6% in adults aged 18 years and older.

For NCDHD, the current prevalence of smoking is equal or greater than the benchmark identified in the cigarette goal; for smokeless tobacco it is equal or greater than the benchmark; and for cigar smoking it is nearly equal to the benchmark. Each of these goals, then, presents an opportunity for improvement.

Alcohol Use

About half of the respondents drink alcohol (49.8%; 2004, 56.4%), and

One in five respondents (18.5%; 2004, 22.6%) have a family history of alcohol problems. In households reporting a family history of alcohol problems, about half (51%) report heavy drinking and 11.8% report binge drinking.

Two-thirds (Q82, 62%) drink infrequently, at most a few times per month, and the remaining third drink once per week (14.7%), a few days per week (18.3%), and daily (5.1%).

Binge drinking: Of all males responding to the 2012 survey, 10% reported binge drinking, while 3% of females reported binge drinking. Of all households, 9.4% reported binge drinking.

In the survey, the greatest differences are across age groups under 35, in which 12-17% of respondents reported binge drinking, compared to 5% for age 55-64 and 1% for 65+.

Self-reported binge drinking across the district and across Nebraska is more prevalent than heavy drinking. Both binge and heavy drinking are more common in men (e.g. in the 2010 BRFSS: males, 25; females, 14%). In the 2008 BRFSS report for NCDHD, binge drinking in the past month was reported by 16.6% of adults in this district, with men (24.7%) significantly more likely than women (8.4%) to report this pattern of alcohol consumption.

Youth and Binge Drinking. In the 2010 YRBS report, 11.5% of youth in the district had engaged in binge drinking (males, 12%; females, 10%; or, 23% of all 12th grade respondents). There is considerable separation for the district between that and the HP2020 goal to reduce the proportion of persons engaging in binge drinking during the past month to 8.5% from 9.4% during the past month in 2008.

Focus Group participants mentioned alcohol and alcohol treatment as one of their concerns. They were concerned about youth and alcohol, and believe that youthful drinking is, in part, the product of few choices, most of which depend on having a school large enough that can offer activities.

Participants also cited the difficulties in getting alcohol treatment and social services, "It is too hard to get help for a family" in some of the communities. Other communities echoed that saying, "people not know about alcohol related services." They also expressed similar concerns about drug abuse, with some comments about specific communities, and that included abuse of prescription drugs.

Ride w/a drinking driver. The HP2020 goal is to reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol to 25.5 percent. About 24% of NCDHD youth reported that they rode with a driver who had been drinking. (About one in five survey respondents (22%) reportedly rode with a driver who had been drinking.)

Miscellaneous

Gambling

In 2012, the proportion of 'gamblers' decreased from 37% in 2004 to 29% in 2012. Of the 394 who play the lottery/gamble, 1.3% reported that it caused problems, and 3% have tried to quit.

Regular Eye Care

Over the six year period defined in the question, 49% of respondents reported regular eye check-ups once a year or less, and for another 28% regular eye exams are within a two-year span (77% within every two years). That is an increase from 2004 from 36% having a checkup at least once per year and 27% additional within the second year (63% cumulative)

In 2004, 11%, never had a regular eye exam; in 2012 that dropped to 5%.

Some of the improvements in vision care may be related to improvements in insurance coverage. Less than half (45%) of respondents reported that their insurance does not cover regular eye care; that is a decrease from the 53% of the 2004 survey. Other changes in coverage occurred where insurance covers *Some costs* (2012, 29%; 2004, 19%) and *Most costs* (2012, 17%; 2004, 15%).

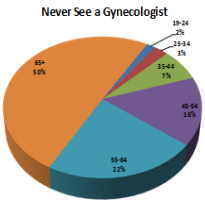
Glaucoma Tests. Though glaucoma tests are often part of regular eye exams, more than one in five of respondents (20%; 2004, 29%) report never having been tested for glaucoma. On the other hand, nearly half (48%; 2004, 37%) report being tested within the past year. Within the past two years, 5% of survey respondents have been diagnosed with glaucoma (2004, 8.6%).

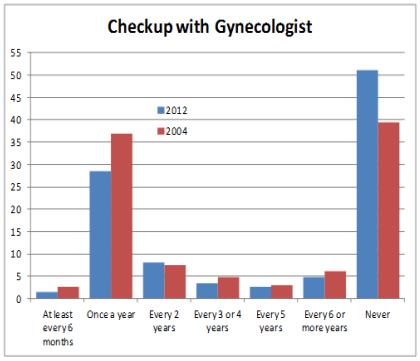
Women's Health

Of the women responding to the survey (average age, 60), 30% visit a gynecologist at least once each year (2004, 39.5%).

Regular Checkups Increase with Education, Income; Decrease with Age.

Never: 51.1%, 2012; 39.4%, 2004)—Increases with Age, Decreases with Income and Education.

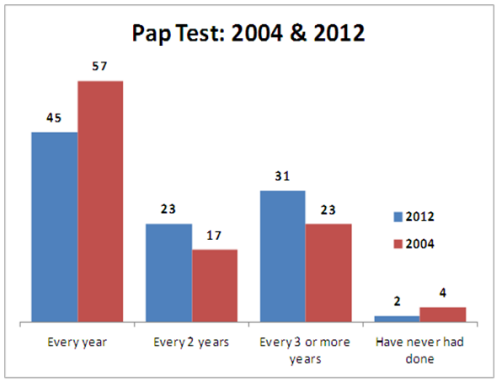




Cervical Cancer

The HP2020 goal is to increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines to 93% from 84.5% of women aged 21 to 65 years. The 2012 survey results (98.5%) *appear to* surpass that goal, as did the results from 2004 (96.5%).

In the HD, 75% of women surveyed in the 2008 BRFSS had a Pap test within the past three years. Using that benchmark would put NCDHD below the 93% target and even below the level reported for Nebraska in 2010 (80.2%).



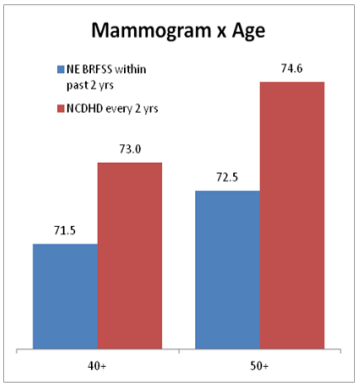
Mammogram Results

- For women 50+, 74.6% of survey respondents had a mammogram within the past two years (50-74 = 77%).
- For women 40+ in the HD, 73.1% of survey respondents have had a mammogram in the past two years.

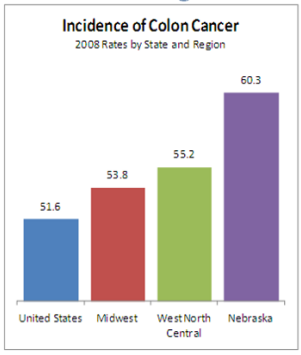
The HP2020 goal, for women aged 50 to 74, is to increase the proportion of women who receive a breast cancer screening based on the most recent guidelines to 81.1% from 73.7% based on the most recent guidelines.

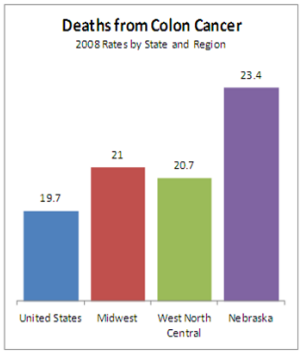
The HD proportions are comparable to the state rate and the national benchmark, but below the 81.1% target.

Note that the 2008 BRFSS report for the HD put the proportion for women 40+ at 63.5%, which was below the state percent and considerably below the target.



Cancer Screening: Colonoscopy





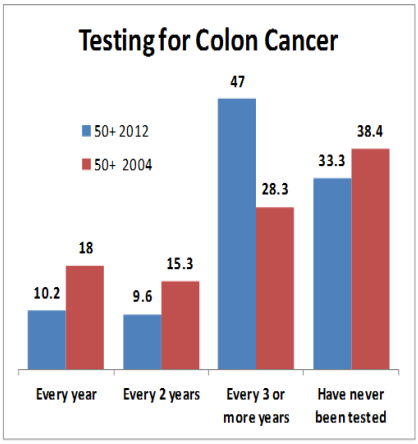
Death & Incidence rates. There are no significant differences between the HD and the state of Nebraska in the rates of incidence or death; however, in comparison to other states, Nebraska rates in the top tier (highest rates) in each of those categories. In the percent screened, it ranks 39th.

Testing

About half (45.9%) of the HD respondents have had either a colonoscopy or Sigmoidoscopy, compared to 61.8% in Nebraska. (For those in the HD, all who had a Sigmoidoscopy also had a colonoscopy, thus 45.9%)

One in four (22.6%) in the HD have had an FOBT in the past 5 years; 15.3% in NE have had an FOBT *within the past two years.*

The proportion screened increases with increases in age, education, and income, both for the HD and for Nebraska.



Colon Cancer Screening Goals

HP 2020 set a target of 70.5% for the proportion of adults aged 50 to 75 who receive a colorectal cancer screening (benchmark, 54.2%).

***Although participation in colon cancer screenings in the health district has increased in recent years, it is significantly lower than that of the state (according to PHAN data). The most telling comparison within this survey is that* 45.9% of the HD respondents have had either a colonoscopy or Sigmoidoscopy, compared to 61.8% in Nebraska, which as a state is lagging in screenings, and ahead in rates of incidence and death when compared to other states.**

Notes: Barriers

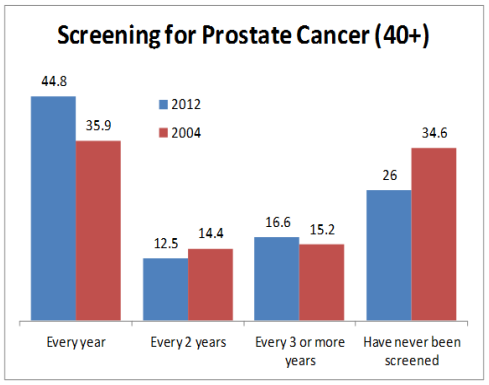
In studies cited by the American Cancer Society:

- General lack of access to health care, often as a result of no health insurance.
- Inadequate communication by health care providers; i.e., the absence of a physician's recommendation for screening reduces the likelihood of screening among both insured and uninsured individuals.
- The differences in patient and provider testing preferences.
- Individuals with the lowest educational attainment and income levels, who have the highest colorectal cancer burden and would thus benefit most from cancer screening, have among the lowest colorectal cancer screening rates, even among insured populations.
- Personal barriers to screening include fear and embarrassment.

Prostate Cancer

Of NCDHD respondents over 40, 57.4% have been tested for prostate cancer within the past two years; one-fourth (26%) have never been screened. That is an increase over 2004 (50.3%), when the percentage of those not screened was 34.6%.

Results for the HD are similar to those of Nebraska. Proportions increase with age and with education.



Maternal Child Health

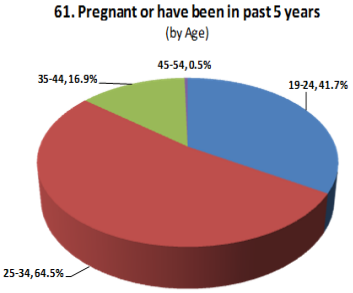
In the 2004 survey, one-sixth (16.6%) of the female respondents reported being pregnant; in 2012 6.8% were pregnant. Of those, two-fifths (42%) were 19-24, and two-thirds were 25-34.

97% are seeing (or saw) a doctor while pregnant.

The average number of doctor visits during the pregnancy was 12.5.

33% (Question 64) took classes on how to care for their new baby; 67% did not.

85% knew where to go or where to call for Prenatal care (care for pregnant women).



With respect to goals from HP2020, survey respondents reported behaviors that exceeded most of the goals covered in the questionnaire (see Table below).

HP2020: Childbirth related goals

HP2020 Goal	Goal	HD Pct.
Took multivitamins/folic acid prior to pregnancy	33.1%	94.2%
Abstain from cigarette smoking during pregnancy.	98.6%	94.2%
Abstain from alcohol (pregnant, 15 to 44 years) in the past 30 days.	98.3%	100.0%
Abstain from Illicit drugs (pregnant, 15 to 44 years) in the past 30 days.	100%	100.0%
Prenatal care beginning in first trimester of females delivering a live birth.	77.9%	97.0%

Children in Households

One in five (21.9%) households had children under the age of 18 living in the home, with an average of 2.1 children per household.

Of those with children, 34.4% had 1 child, 36.9% had two, and 19.1% had three children.

Check-ups, etc.

Physical Exam. **Of those with children, 90.8% (2004, 80.2%) reported that their children had a physical within the past year.**

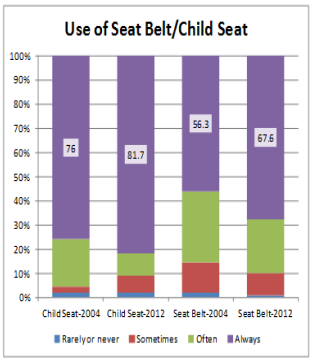
About one in ten (8.5%) said their children did not have a checkup in the past year.

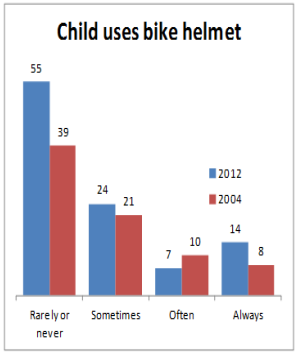
Dental. **Of the children under 3, four of five (84.1%; 2004, 80.1%) saw a dentist during the past year; 14.8% (2004, 16%) did not.**

Immunization. **Nearly all of the children (96.8%) are up to date on their immunizations, a nearly identical response to the 2004 survey.**

Nutrition. **In those households with children, three in four children (81.2% 2004, 74%) living in the HD *always* eat at least three meals per day, and another one in eight (12.3%) *Often* do.**

Automotive Safety: Child Seats and Seatbelts. Of 142 families with children under 6, 82% (76%, 2004) *always* use a child seat, while another 9.2% *often* use a child seat. Of households with children over age 6 (N=256), the *always* category for seat belt use increased to 67.6% (2004, 56.3%), while the *often* category was at 22.3% (2004, 29%).

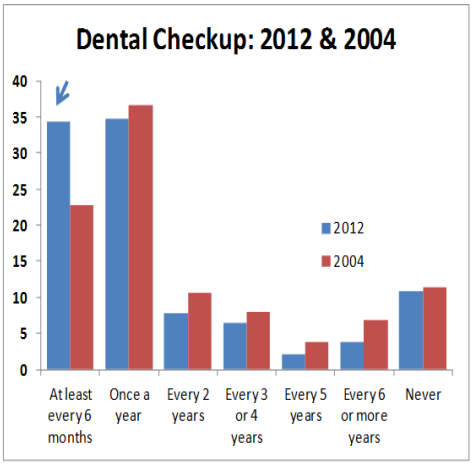




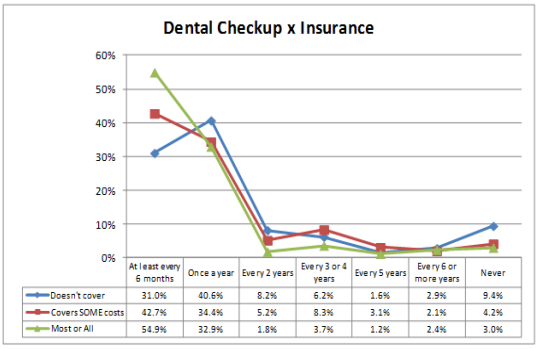
Dental

Results. The proportion of adult residents (69%) who have visited the dentist within the past year is well ahead of the HP2020 Goal (49%). It is also an increase over the 2004 study in which 59% have visited the dentist within the past year.

Most of the children 3 and older (84%) have had a dental checkup within the past year, nearly double the HP2020 target.



Insurance & Dental Checkups



	At least every 6 months	Once a year	Every 2 years	Every 3 or 4 years	Every 5 years	Every 6 or more years	Never
Doesn't cover	31.0%	40.6%	8.2%	6.2%	1.6%	2.9%	9.4%
Covers SOME costs	42.7%	34.4%	5.2%	8.3%	3.1%	2.1%	4.2%
Most or All	54.9%	32.9%	1.8%	3.7%	1.2%	2.4%	3.0%

Other Sources: CAN

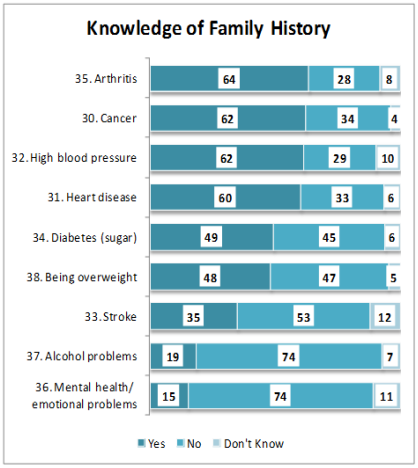
- **Two-thirds (66%) of respondents *Sometimes (43%) or Always (23%) delay seeing the dentist.***
- **Half (50%) say that affordable dental care is a *somewhat/very serious problem* for the family.**

Diagnoses by Health Professional

The survey included a series of questions reflecting the currency of diagnosed conditions (past 2 years). The most common of those was high blood pressure followed by high cholesterol, and overweight/obesity.

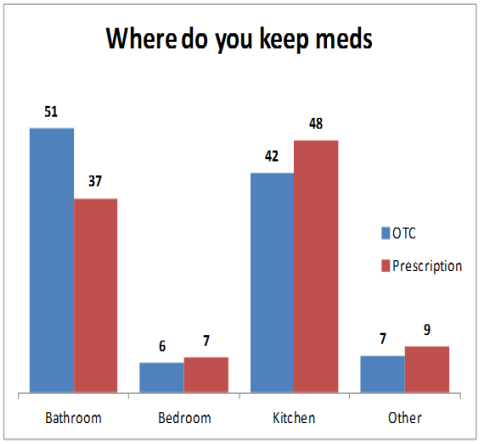
Diagnosis	Frequency	Pct	Diagnosis	Frequency	Pct
High blood pressure	*503*	33.7%	Skin cancer	*76*	5.1%
High cholesterol	*459*	30.8%	Colon or rectal cancer	*13*	0.9%
Arthritis	*401*	26.9%	Breast cancer	*13*	0.9%
Obesity /overweight*	*280*	18.8%	Lung cancer	*6*	0.4%
Thyroid problems	*233*	15.6%	HIV / AIDS	*5*	0.3%
Heart problems	*180*	12.1%	Cervical cancer	*3*	0.2%
Diabetes (sugar)	*165*	11.1%	Prostate	*3*	0.2%
None	*143*	9.6%	STDs	*2*	0.1%
Glaucoma	*76*	5.1%			

Family History



Medication: Storage and Disposal

Overall, the kitchen and bathroom are the preferred storage place for medication.

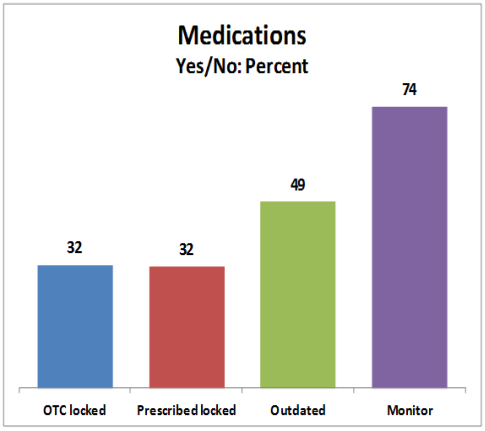


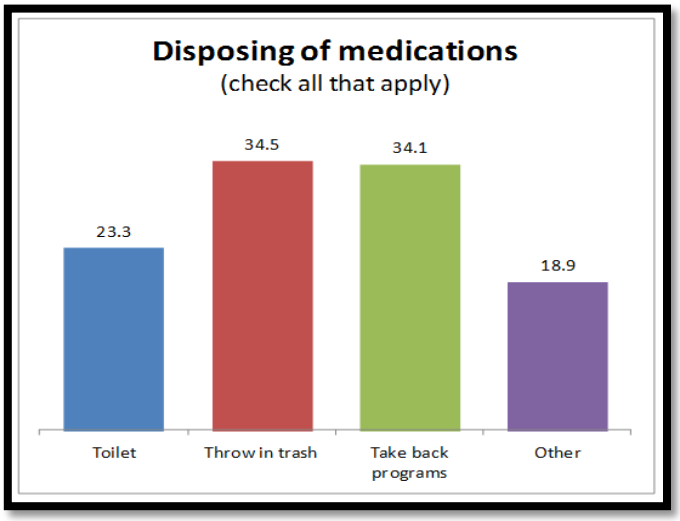
Medications (cont.)

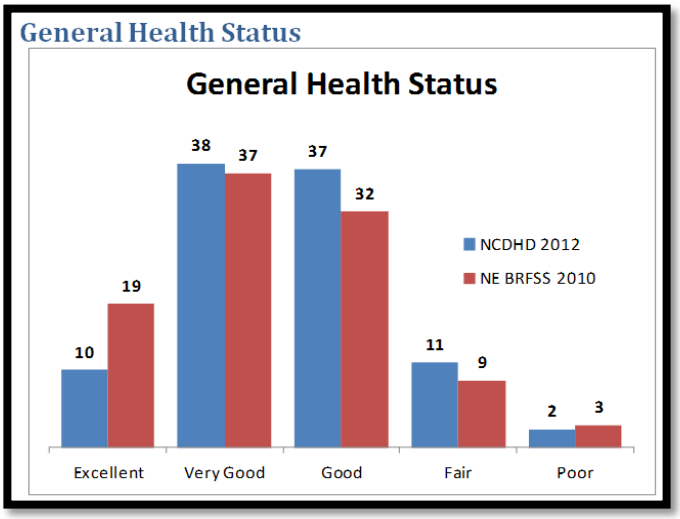
One third of households (32%) keep prescription and OTC medications in a locked location.

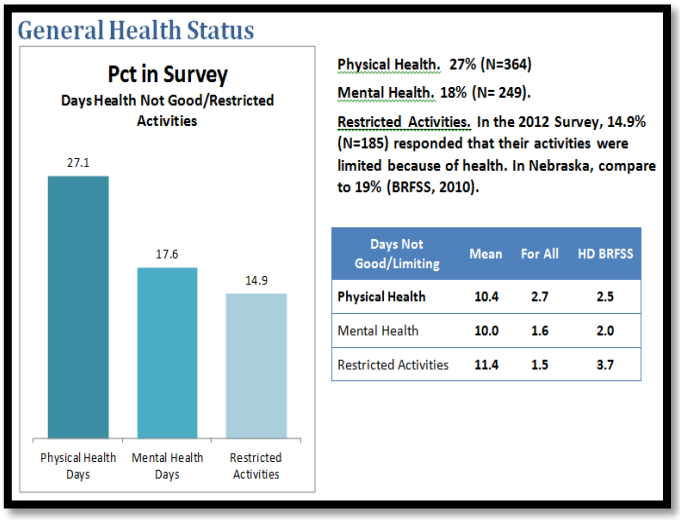
Of those households that have at least one child, 42% keep OTC medications in a locked location.

Of those households that have at least one child, 41% keep prescription medications in a locked location.









Days Not Good/Limiting	Mean	For All	HD BRFSS
Physical Health	**10.4**	**2.7**	**2.5**
Mental Health	**10.0**	**1.6**	**2.0**
Restricted Activities	**11.4**	**1.5**	**3.7**

10.B COUNTY FOCUS GROUP MEETING NOTES

NCDHD Community Health Improvement Planning

County Focus Group Meeting Notes – Summary of Corresponding Concerns

Comments from all county focus group meetings were reviewed to determine issues or concerns that came up in more than one location. Those concerns are captured in the list below. The following pages document all comments noted for each county focus group meeting.

Chronic Disease, Obesity and Related Health Concerns

- Education needed – prevention, nutrition, managing your chronic disease
- Diabetes concerns
    - Correlation between diabetes and heart disease, diabetes needs to be managed to prevent obesity or need for hospital care, lack of resources in place to assist with compliance
- School lunch concerns
    - Sometimes this is the only meal kids get, some kids don't eat at school, impact of school lunch regulations in relation to childhood obesity, there are calorie restrictions on school lunches

Behavioral Health – Substance Abuse

- Prescription drug abuse concerns
    - Significant need for electronic prescription medication database
- Elderly prescription concerns
    - Primarily attributed to education, medication management, or ability to take medications correctly
- Concerns with youth consumption of energy drinks
- Concerns with teen drinking or prescription drug abuse – learned behavior from parents or parental attitude/acceptance/environment does not serve to prevent
- Marijuana use increasing

Behavioral Health – Mental Health

- Access to care is most significant barrier – affordability, availability (lack of providers, facilities)
- Medication management or ability to afford medication leads to issues
- Emergency Protective Custody (EPC) issues
- Stigma prevents people from seeking care, especially in smaller communities
- Issues with being properly diagnosed

Access to Care

- Struggle with getting new providers (medical/dental/mental health) to come to rural areas, lack of providers who accept Medicaid
- Care for seniors and youth seem to suffer in smaller communities due to lack of services
- Access to care is related to economic situation
    - Affordability of health care, affordability/availability of in-home or nursing home care for elderly, gap between being able to afford care/insurance and not qualifying for Medicaid/Medicare, resources need to be available during food pantry hours, need more information about resources and charity care / free services
- Transportation is a big concern
- Insurance concerns – premium affordability, less adequate coverage, effect of health care reform, Medicaid/Medicare difficult to obtain and funds being cut
- Lack of medication/prescription availability
- Dental concerns
    - Dental health affects all aspects of a person's health, lack of financial resources to pay for own dental care
- Senior care concerns
    - Financial burden is a big concern, lack of resources/services, population is aging

Cancer Prevention and Education

- Focus is needed on education, awareness, and preventive measures

Environment and Safety

- Concerns about healthy home environments
    - Family values and morals have changed, family situations are different, quality family time needs to be important, child abuse/neglect is an issue, no follow-up or response to reports of abuse/neglect, truancy issues related to home environment
- Concerns over level of safety in schools
- Internet gives youth access to everything
- Lack of safe, affordable housing

County/Location: Antelope / Neligh

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• n/a
Behavioral Health	**Substance Abuse**	• Hospital does see some prescription drug abuse – need to have an electronic pharmacy registry to track when prescriptions are filled • Prescription med abuse in the elderly – don't take their medications properly: AMH has a lunch bag program that they have used that people bring their medications in to the clinic • Doesn't appear to be as much meth use as a few years ago • Marijuana is the gateway to meth use • Binge drinking is socially acceptable – parents do it so it is okay for their kids to do it
	Mental Health	• Many not able to get in to see counselors • Not a lot of services for adolescents • Have used Telehealth in the past for counseling services • Many are not able to afford mental health services
Access to Care		• Senior care is a burden on the health care system • Seniors lack money and often don't get proper nutrition • Not many places that provide services for the elderly and if they do they are very expensive and they can't afford it • Many schools with limited school nursing hours – they are unable to provide education on nutrition, physical activity, etc. • Dental care – unable to recruit new dentists • Not as many dental issues associated with meth as seen in the past • Hospital doesn't see a lot of people with dental issues • 10% of population in Neligh is Hispanic • Not able to find interpreters in health care settings – they are very much in need
Cancer Prevention and Education		• n/a
Environment and Safety		• Family values and morals have changed – violence in video games, on TV and internet access to everything • Training in schools for safety of staff and students • Have a police officer in the school to interact with students, can notice students experiencing difficulties and intervene (in the Norfolk high school at this time) • Lack of parental supervision, confusing family situations • No responsibility for parents to care for their children, a lot of co-dependency • Need major focus on children – able to change behaviors in young children • Elder abuse seen- they don't receive proper care, some families keep elderly at home to save money and others don't want the elderly in a nursing home and try to care for them on their own

County/Location: Antelope / Tilden

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Nutrition – many kids without breakfast and supper • School requires student to have a fruit and a vegetable for their meals – kids aren't eating them and there is a lot of waste • Calorie restrictions on amount of food served in schools
Behavioral Health	**Substance Abuse**	• Occurs in many households • Alcohol usage in schools has remained about the same over the past 20 years • Increase in usage of marijuana • Prescription drug abuse seen more in adults – kids have prescriptions that they aren't taking because parents are taking them instead • Youth drinking too many energy drinks although has seemed to decrease over past year
	Mental Health	• Have protocols and crisis response teams for school emergencies/tragedies • Lack of providers and mental health facilities • More mental health services for those directly involved in tragedies – how to get them the help they need • Need mental, physical and spiritual health for everyone, if one part of the three is missing the person is not whole • Spirituality is often taken out of things because it is offensive to some people
Access to Care		• Not enough providers – new providers typically don't come to rural areas • Youth with Medicaid are not able to access treatment • Many providers do not accept Medicaid • Lack of financial resources in families to pay for own dental care • Dental health affects all aspects of a person's life and health systems • Senior care services – they had a 45 bed nursing home that had to be closed • Have many resources: new assisted living facility, clinics, hospital, hospice and counseling services • Seniors have limited financial resources • Home health – staff are extended and business comes in spurts • Some seniors can't afford assisted living or care in homes • Difficult to find 24 hour care for seniors in their homes • Need to look to the future in regards to senior care and be more creative on how to handle growing population of seniors • Baby boomers are reaching senior ages soon and there is not adequate health care systems in place to handle the large increase in the senior population
Cancer Prevention and Education		• More education needs to be done
Environment and Safety		• School safety: are the schools really safe and what needs to be done in order to ensure the safety of the students and staff • Have first responders visit the schools so they are familiar with the layout of the school • Have a "safe place" designated in each school where the students and staff can go • Should a school staff member be allowed to have a concealed weapon in the school (training for how to respond to an incident) • Schools should have drills and have crisis response teams • Law enforcement present at all schools in mornings and periodically throughout the day • ID badging for school staff • Internet access – able to access all types of information • Family units/community togetherness – how to keep them together, values and morals have changed, we have a sense of "protection" that nothing bad will happen here

County/Location: Boyd / Spencer

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Diabetes and heart disease – need to have educational programs for the public • Seem to have active people in community in regards to physical activity, especially younger women • Weight room at the school in Spencer is open to the public • More education needed on diet & nutrition – food preparation, recipes, how to eat right
Behavioral Health	**Substance Abuse**	• Don't feel there is much prescription drug abuse • Canine units in schools may be good – where is the closest one located, bring it into schools for monthly checks to scare the kids into knowing that they will get caught • See a lot of people that use chewing tobacco
	Mental Health	• Difficult to find someone to help those who are in need • No mental health providers within the county • No psychiatrists around, usually only come for medication checks • Many people don't want to seek mental health services because of the stigma associated with this – small communities and people will see them and talk
Access to Care		• Smaller communities don't have as many services to offer – senior care and youth • Only 1 dentist in Boyd County, he is 70 years old and may not be taking any new patients – unable to recruit any new person to take his place • Location has been a hindrance for recruitment of dentists, physicians, etc. • Not many physicians, many are older and close to retirement • Need to promote health care fields in schools at career fairs, etc., maybe using telehealth • Access to care is difficult – need to have more free services available for communities • Many seniors need more care than they are receiving and there are not many services available to provide them with assistance • Have 1 nursing home and 2 assisted living facilities in Boyd County • There have been funding cuts to the Nebraska Area Agency on Aging
Cancer Prevention and Education		• Niobrara Valley Hospital looking to find new ways to promote colorectal cancer screening • Niobrara Valley Hospital conducted free prostate screening, will be done again in March or April
Environment and Safety		• Niobrara Valley Hospital is looking at implementing a bike helmet program and child safety seat checks • Some dilapidated buildings – communities are doing much better at taking care of this matter – city council has worked on this in Spencer • Lynch has a movie theater ran by local volunteers. • A lot of people in the area volunteer for many things, they are becoming extended and it is hard to implement any new activities. • A lot of community pride in keeping things nice.

County/Location: Brown / Ainsworth

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Childhood obesity as related to school lunch regulations • Increase of childhood obesity
Behavioral Health	**Substance Abuse**	• Need electronic database for prescription drugs • Marijuana use is increasing • Steroid use among youth • Use of energy drinks by youth
	Mental Health	• Identification of diagnosis • Resources not available or accessible. Transportation big issue • Access to care • Cost • Stigma • Waiting lists for care
Access to Care		• How does health care reform affect services • Shortage of some drugs • Oral health accessibility • Lack of fluoridation • Local Alzheimer's unit closed • Need for monitoring of seniors • Insurance-higher deductibles and less adequate coverage • Many people do not know about Charity Care or do not follow through • Do not have baselines concerning men's health • Need for more specialty physicians • Need breastfeeding and lactation support • No birthing facilities- must travel for prenatal classes
Cancer Prevention and Education		• n/a
Environment and Safety		• Internet safety • Physical safety at school, in hospital and businesses • Child abuse & neglect- unresponsive resources, increasing issues • Decent, affordable housing not available • Substandard housing- lead, mold and radon

County/Location: Cherry / Valentine

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Dietary services only covered for diabetics and kidney disease • Preventative education needed • Obesity & tobacco can be tied to most chronic disease
Behavioral Health	**Substance Abuse**	• Alcohol, prescription drugs, abuse of household products, huffing, Lysol, etc. • Prescription abuse is primarily from youth to middle age • Elderly abuse is related to medication management and understanding • Theft of prescription pads • People going to multiple providers • Not going away
	Mental Health	• Management issues • Economics- insurance/ preventative coverage • Need more providers • EPCs often don't get admitted
Access to Care		• Charity Care at hospitals going up • Health insurance premiums are a barrier • Stereotyping barriers keeps people from seeking care • Access to care is related to poverty, especially emergency services • Dental care- few providers • Dental status is related to other health issues • Many dental providers will not take Medicaid clients
Cancer Prevention and Education		• n/a
Environment and Safety		• Increased truck traffic • Child restraints • Bike helmets • Gun safety- is education taking place? • Housing- finding affordable housing • Substandard housing • Landlords not safety conscious • Native American issues: substance abuse, domestic violence, health issues, abuse of system, chronic disease- diabetes, cirrhosis of liver, health system complicated, detox & treatment issues, demographics in schools changing

County/Location: Holt / O'Neill

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Diabetes is a huge problem we are forgetting. • Diabetics need to keep up on their routine doctor checks so they do not end up needing hospital care. • Diabetics are also a big population that has cardiovascular problems. • Keeping up on healthy choices so they do not become obese.
Behavioral Health	**Substance Abuse**	• Prescription Drug (PD) use is a big problem in our district. • PD is very easy to get ahold of. • Most elderly have an array of prescription drugs they take every day. • Alcohol continues to be the #1 problem. • Teen drinking is a problem • The parent's perspective of drinking and how they portray it.
	Mental Health	• Can't afford health care so stop taking medication and end up going into Emergency Protective Custody (EPC) as a cause of it.
Access to Care		• Growing population of elderly - 65% of our district is elderly. • Medicaid availability for elderly in nursing homes. • Affordable care/insurance for elderly in nursing homes. • Medication management • A lot of people don't know how to access affordable health care. • Rural areas do not have free service facilities so people do not think it is an option. • 65 and older people lose jobs but cannot qualify for Medicaid and can't afford to live on having a part-time job. • Need a list of available resources, create a resource book. • Low paying jobs in our area, people can't afford care or to live here. • Have resources available during food pantry hours. • Using Economic Development as a resource.
Cancer Prevention and Education		• Putting off preventive care until it's too late. • Hospitals are doing a great job at promoting colon screenings. • Providing more checks/screenings during health fairs. • Providing services during food pantry hours.
Environment and Safety		• Home life stability, how that affects everything. • Children are not able to be home enough, involved in lots of activities, which is good, but less time is spent around the supper table as a family. • Housing owners do not want to enforce healthy environments. • Demolition of old abandoned houses that could be bad for one's health. • Elderly being stuck in their homes not knowing about the resources available to them. Unhealthy environment. • Rural youth work more jobs than urban youth.

County/Location: West Holt / Atkinson

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• As related to risk for diabetes
Behavioral Health	**Substance Abuse**	• n/a
	Mental Health	• Families who live "on the fringe"- mental health issues, substance abuse • Suicide • Medication management/ family dynamics, priorities • Increased number of students taking medications • Bullying
Access to Care		• Big gaps • Are we measuring preventative services and effectiveness • Transportation issues • Medicaid issues • More Charity Care cases • More people coming to ER • Need more parish nurses • More students not getting preventative oral health • Waiting list- dentist • Need dental providers • No pediatric dentists • Transportation
Cancer Prevention and Education		• n/a
Environment and Safety		• Housing- need affordable and safe - many substandard, slum lords • Keeping kids in schools when family cannot find place to live • Lack of employable skills • Services are often reactive rather than preventative • Getting grant funding brings more regulations • School related issues- increase in those qualifying for free lunches, clothing needs, food, children run out of needed meds

County/Location: Knox / Creighton

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Those with chronic disease need more assistance, have difficulty navigating health care system • Many fall through the cracks • Tend to be non-compliant at home and many times have inpatient stays due to this • Health literacy is an issue – have been using the teach back method where patient states three things to ensure that learning has occurred; also use demonstration of skills • Santee has a large number of diabetics with specific diets that need to be followed– lack of fresh healthy foods available, the grocery store there doesn't have fresh produce, etc. and many times the residents are not able to afford driving to other communities to purchase these food items so there is a lot of noncompliance with their diets – they are looking into "Street Farmer" to show them how to grow their own fruits and vegetables • Some current issues with teens not eating in the schools • Nutrition in schools – an increase in students bringing their lunches, smaller portion sizes
Behavioral Health	**Substance Abuse**	• Teen drinking is a problem • Boredom for teens, lack of activities for them to participate in other than sports • Parents accept teen drinking in this area (parents did it so okay for their teens to drink) • Energy drinks (some contain alcohol) – Knox County Extension Office has a display regarding energy drinks – some communities have age limit on purchase (18 years and older) • Need Pharmacy Database so pharmacists can see when prescription medication was last refilled • Prescription drug abuse occurring in adults and teens - appears to be enabled by parents (parents take grandma's pills so they in turn take their parents' medications) • Patients go to many different facilities to seek prescriptions (typically for pain)
	Mental Health	• Only one mental health provider that offers home visits in the county • Lack of access • Use telehealth to address lack of access
Access to Care		• Lack of access to dental providers who accept Medicaid • Lack of access to dental screening • On-line training course to learn how to apply fluoride varnish, provides a certificate, does not need to be a dental hygienist or dentist • Staffing shortages in long-term care (CNAs and nurses) leads to lack in continuity of care • Abuse of the health care system – people are using the ER instead of waiting to see a provider during normal hours, mainly those with Medicaid • No urgent care available • Avera Creighton Hospital has an after hospitalization program called "Care Transitions" – the nurse completes a home visit and does a medication check to help with compliance, and make follow-up phone calls with the patient • There are many restrictions for home health coverage, if person is not homebound, they have to pay privately for the care • Many with chronic disease or elderly need assistance with daily chores
Cancer Prevention and Education		• People without health care plans don't see providers for screenings and checkups, so there is a lack of education about what screenings are needed and at what ages they should be done • For those without health care plans the screenings are cost prohibitive • Avera Creighton had a mobile mammogram unit – did not have as many people utilize this service as they were expecting
Environment and Safety		• Children not in healthy home environments – they are reported to the state according to protocol and follow the chain of command but nothing seems to get accomplished • Lack of resources for follow-ups listed above or no follow through • Not a lot of foster care homes available in the area • Lack of juvenile services available (detention centers) • Bullying by both adults and children • Truancy issues (particularly in Santee), parents don't enforce their children's attendance in school – this leads to an increase in the opportunity for teens to engage in high risk behaviors

County/Location: Pierce / Foster

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Diabetes is a factor in some cases of obesity. • Cardiovascular disease has decreased since smoking has been banned in bars. • Great that school lunch programs are reducing bad food, but now more kids bring lunch from home or go off campus to eat.
Behavioral Health	**Substance Abuse**	• Medical marijuana use is increasing. • Fear of it only being a matter of time before marijuana becomes legalized in more states. • Increase of prescription drug use. • Having more safe ways to take back prescription drugs. • Youth binge drinking will continue to be a problem.
	Mental Health	• People need to be treated, but it's hard to get in and see someone who can actually diagnose a mental illness. • Getting kids into a mental health program, and not knowing where to take them. • People don't think it's a big deal until it's too late. • EPC issues, where they take them and how long they can be kept.
Access to Care		• Finding where to go for children with mental health issues. • One of the problems could be that mental health provider jobs are being cut. • Making sure people show up for meetings and together try to get information out there. • Region 4 contracting with the hospitals is a good way to help spread information. • Medicaid and Medicare funding will be getting cut. • Some agencies cover such large areas and are strung out too thin. • Affordable nursing home care for our elderly. • 75% of the dentists in our district will be retiring soon. • The Hispanic populations in our area have difficulty finding oral health care. • Affordable dental insurance. • A gap of people who are being missed, those who can't afford dental care, but don't qualify for Medicaid or Medicare. • Pharmaceutical availability. • The delay when getting prescription drugs. There are so many drugs it's hard for pharmacists to keep them all in stock. • Medicaid is very difficult to get now. • Can't afford to have in home care for elderly and it is hard to find someone who will do it privately due to liability issues. • Nursing homes are having an overflow. • Can't afford to have health care. • Elderly having to give everything they own to afford to be taken care of in a nursing home.
Cancer Prevention and Education		• Believe it is helping that FOBT kits are being handed out so much more, especially at health fairs.
Environment and Safety		• Economic development. • The family structure. Sitting down as a family and having a meal. • School safety. • Has been helping since smoking was banned in bars.

County/Location: Rock / Bassett

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Sedentary life style for many • Youth not as physically active
Behavioral Health	**Substance Abuse**	• Mixing "Red Bull" with alcohol • Energy drinks are an issue • Prescription drug misuse by seniors • Transient population seeking drugs • Youth know who to contact to get drugs • Marijuana is present • Prevalent use of smokeless tobacco products by youth and adults
	Mental Health	• Only one mental health provider in county
Access to Care		• Issues for seniors to access DHHS services via computers • Many insurance issues • Payment difficulties for seniors utilizing Senior Center • Nail care not available • Inadequate dental services • Cost of dental care prohibitive for many • Vision care not available in the county • Concern about Medicare payment
Cancer Prevention and Education		• Appears to be high incidence of colon cancer in county • Must travel for cancer treatment
Environment and Safety		• Unsafe cell phone use • Lack of proper use of child safety seats an issue • Use of bicycle helmets is minimal • Lots of vandalism • Farm & ranch safety- people don't take precautions • Concern about farm chemicals used • Some child abuse, more child neglect • Children going home to empty, unsupervised houses • No after school program • Lots of single parent households • Housing issues- not the kind of housing people want, some substandard housing • Need for assisted living facility • Fluoride no longer in water system in Bassett • Population loss in community leading to loss of services • No adequate child care available